VETERANS' ADMINISTRATION MEDICAL CONSTRUCTION BUDGET

HEARING

BEFORE THE

SUBCOMMITTEE ON
HOSPITALS AND HEALTH CARE

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

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THE VETERANS' ADMINISTRATION MEDICAL CONSTRUCTION BUDGET

WEDNESDAY, MARCH 16, 1988

U.S. HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, D.C.

The subcommittee met, pursuant to notice, at 9 a.m., in room 334, Cannon House Office Building, Hon. G. V. (Sonny) Montgomery (chairman of the subcommittee) presiding.

Present: Representatives Montgomery, Penny, Staggers, Rowland of Georgia, Bryant, Kanjorski, Stenholm, Harris, Kennedy, Hammerschmidt, McEwen, Smith of New Jersey, Bilirakis, and Ridge.

Also present: Representative Johnson of South Dakota.

OPENING STATEMENT OF CHAIRMAN MONTGOMERY

Mr. MONTGOMERY. Good morning. The purpose of the hearing this morning is to receive testimony about the VA's medical construction program.

It is important to remember the fundamental nature of the construction program. It makes possible the delivery of quality health care.

We appreciate Dr. Gronvall and the others coming up again and talking to us.

I will not read this full statement. What I will say to my colleagues and to those who work in construction is that I was at the Twin Cities in Minneapolis Saturday, and I saw the VA hospital there. That is some kind of hospital. It is the nicest hospital or hotel I believe I have seen since I have been traveling around.

As I understand it, it was done by looking at the local effort and getting a feel from people there to the climate and what would be needed. I would recommend to my colleagues that if they have the opportunity, they should go and look at that hospital. It is really very attractive, and everything is designed with the latest skills for the out patients, for hospital care, and for families. I was really impressed.

It is my understanding that you did consult with local efforts and had input from people in that area. It will make many people take a good hard look at our programs and what a terrific job has been done there.

We requested an increase in hospital construction, and, in effect, we didn't get it. We wanted to build more. Most of our buildings are over 30 years of age, and they just have to have some maintenance on them.

We recommended $15 million for design funds in our new budget proposal to the Budget Committee for the spinal cord injury center at the Dallas VA Medical Center and $16 million for three nursing homes. We passed that out of the committee, and it has gone to the House Budget Committee for nursing homes at Mountain Home, Tennessee; Wilkes-Barre, Pennsylvania; and Gainesville, Florida. We thought that was a modest increase in the building program.

[The prepared statement of Chairman Montgomery appears on p. 39.]

My colleagues, Jim Traficant of Ohio, Sonny Callahan of Alabama, and Patrick Swindall of Georgia have submitted testimony for inclusion in the hearing record. Without objection, it is so ordered.

[The prepared statements of Representatives Traficant, Callahan, and Swindall appear on pp. 42, 43, and 45.]

I want to welcome our witnesses, and, at this time, I would like to recognize the ranking member of the subcommittee, John Paul Hammerschmidt.

OPENING STATEMENT OF HON. JOHN PAUL HAMMERSCHMIDT

Mr. HAMMERSCHMIDT. Thank you, Mr. Chairman.

I was impressed when you said that that Minneapolis hospital was about the best you had seen from all your traveling around. That covers a lot of ground, Mr. Chairman.

Mr. Chairman, everyone recognizes that the VA's proposed budget for fiscal year 1989, including construction, has been tightly constrained by the fiscal situation facing the entire government. Given that constraint, the VA's request for 1989 construction funding is slightly less than it was for the current fiscal year by some $22 million, as you observed in your statement.

Obviously, we can't do everything we would like to do, but I think adding back the three nursing homes, Mountain Home, Tennessee; Wilkes-Barre, Pennsylvania; and Gainesville, Florida, as the committee's budget report recommends, is a badly needed restoration. It will help to address the most critical need of the VA health care system in the foreseeable future needs for nursing care as the number of older Americans dramatically increases.

$31.4 million for the nursing homes and Dallas clinical addition and spinal cord injury unit would put the VA's construction budget approximately where it is for the current fiscal year, considering inflation. Mr. Chairman, I commend your vigorous leadership in the effort to keep the VA at the current services budget. I think you have identified exactly the right places for more funding.

Also, Jerry Solomon, the committee's ranking member, has been working hard for adequate VA construction funding. I salute him as well.

The committee's recommended construction budget differs in detail very little from that of the VA. Because the VA's construction planning is increasingly supported by information about actual needs and the comprehensive national picture, a number of improvements in the overall construction process have yet to be made, but the VA appears to recognize their necessity, and I hope they will come rapidly, because they hold great promise for cost savings while better meeting veterans' health care needs.

Mr. Chairman, I join you in welcoming our witnesses from both the VA and the veterans' service organizations. I look forward to hearing more about the independent construction budget formulated by several of the service organizations. It is immensely helpful to us, not only in terms of the budget numbers but also in terms of providing a consumer perspective in the vital area of VA activities.

Mr. Chairman, our proposed construction budget of some $530 million is going to be carefully scrutinized by the Budget and Appropriations Committees, and I trust we can count on the continued support of the veterans' services organizations and the members of those committees. We must all stay together or risk losing a proper share of the fiscal year 1989 budget for the Veterans' Administration.

Thank you, Mr. Chairman.

[The prepared statement of Representative Solomon appears on p. 46.]

Mr. MONTGOMERY. Thank you, John Paul. I appreciate very much your being here along with other members of the subcommittee.

Would any other member of the subcommittee like to make any comments before we recognize the witnesses?

[No response.]

Mr. MONTGOMERY. If not, our witnesses are at the table. Mrs. Livingstone, they kind of have you on the end there, but I believe you are going to do the opening remarks. Either Dr. Gronvall or you can introduce those at the witness table with you.

STATEMENT OF SUSAN LIVINGSTONE, ASSOCIATE DEPUTY ADMINISTRATOR FOR LOGISTICS, VETERANS' ADMINISTRATION; ACCOMPANIED BY: JOHN GRONVALL, M.D., CHIEF MEDICAL DIRECTOR; ARTHUR J. LEWIS, M.D., DEPUTY CHIEF MEDICAL DIRECTOR; DANIEL H. WINSHIP, M.D., ASSISTANT DEPUTY CHIEF MEDICAL DIRECTOR FOR PROGRAMS AND OPERATIONS; GERALD E. NEUMANN, DIRECTOR, OFFICE OF FACILITIES; AND ROBERT L. NEARY, DIRECTOR, OFFICE OF PLANNING AND DEVELOPMENT, VETERANS' ADMINISTRATION

Mrs. LIVINGSTONE. Thank you, Mr. Chairman.

As you will notice from the papers I carry, I always have to sit at the end to have enough room to spread out. That was sort of a preselection on my part.

In the interest of time, I will not summarize our formal statement, but I would ask that it be submitted for the record.

Mr. MONTGOMERY. Without objection, so ordered.

Mrs. LIVINGSTONE. We are very pleased to be here this morning to respond to any questions you may have on our fiscal year 1989 budget request.

With me this morning is Dr. Dan Winship who is our Assistant Deputy Chief Medical Director for Programs and Operations. Next to him is Dr. Arthur Lewis who is our Deputy Chief Medical Director. Next to Dr. Lewis is Dr. John Gronvall who is our Chief Medical Director, then Mr. Jerry Neumann who is our Director of the Office of Facilities, and Mr. Robert Neary who is the Director of our Office of Planning and Development in the Office of Facilities.

With that, we look forward to our discussions with you this morning.

Mr. Montgomery. You don't have any opening remarks you wish to make?

Mrs. Livingstone. Mr. Chairman, we had submitted a rather lengthy formal statement for the record, and I thought in the interest of time, that would suffice to cover most of the points that we wanted to make.

Mr. Montgomery. That will be fine with us.

[The prepared statement of Mrs. Livingstone appears on p. 48.]

Mr. Montgomery. Mr. Hammerschmidt?

Mr. Hammerschmidt. Mrs. Livingstone, the other day, testimony was given that during all the last year, VA only converted 18 hospital beds to nursing care beds although you had planned to do a great deal more. Would you please comment on the shortfall and also comment on your conversion plans for this year?

Mrs. Livingstone. Mr. Hammerschmidt, I would like to ask Dr. Gronvall to respond to that question.

Mr. Hammerschmidt. Dr. Gronvall?

Dr. Gronvall. I appreciate very much your asking the question, because I think we gave a very brief answer the other day and didn't have time to set it in context.

During fiscal year 1987, we, in fact, added to the system some 383 new nursing home beds. That came about through the addition of 300 new nursing home beds from projects that were completed and activated during that year. We brought on line 18 beds that were converted from existing hospital beds and then added another 65 nursing home beds through adjustments within nursing homes across the system.

So, all of those things resulted in 383 nursing home beds being added during 1987.

The specific answer we gave during the March 2, 1988, hearing was correct, that by direct conversion of hospital beds to nursing home beds, we did only add 18 beds in 1987. There were other projects that had been projected in the 1987 budget when it was submitted. A couple of those projects were delayed. One, in particular, at Buffalo was delayed, because once we got into serious planning, we discovered asbestos in the part of the hospital that was going to be converted to a nursing home. That delayed the project, so it was not completed during 1987 and was carried over into 1988.

Therefore, those beds that had been projected originally to be converted in the 1987 budget did not come on line during the year.

Mr. Hammerschmidt. There was a prototype nursing home, apparently, that was approved in February of 1987. Are you using it, or what is the status of that?

Mrs. Livingstone. Mr. Hammerschmidt, we are using that prototype design on our major construction projects. It is not applicable in its full entirety, of course, to conversions in which you are dealing with existing space.

Nursing homes that have been targeted for use of the prototype include the Prescott, Arizona project that was funded in fiscal year

1985, and that is under construction. In addition, we are using it in Amarillo, for the Pittsburgh nursing home that is in the fiscal year 1989 budget request which is a 240-bed nursing home care unit, in Tuscon, Arizona, and on the Saginaw nursing home that was added to the budget in fiscal year 1988.

Mr. **HAMMERSCHMIDT**. When will you do that?

Mrs. **LIVINGSTONE**. In terms of Saginaw?

Mr. **HAMMERSCHMIDT**. Yes.

Mrs. **LIVINGSTONE**. That project is under consideration for approval for the fiscal year 1988 advance planning fund. As soon as the approval is received, sir, we will be moving forward to apply the prototype design to that project.

Mr. **HAMMERSCHMIDT**. Thank you.

On a broader overview, could you give the committee a preview of your nationwide study of VA hospitals as to their physical condition, and has the study caused you to alter any major construction projects?

Mrs. **LIVINGSTONE**. Mr. Hammerschmidt, that study has been completed, and we have just finalized an analysis which basically is taking a look at the findings in that study and determining what portion of the corrective actions that have been identified have already been funded and/or planned by the facilities in their five-year plan.

The overall study included, as you perhaps know, 132 of the VA's 172 medical centers that were constructed prior to 1970. The study identified corrective actions on the order of magnitude of about $1.325 billion. However, almost 80 percent of that has either been funded or has been planned for corrective action.

We are applying the capital facilities study to our construction planning and have been using the analysis even as it was being developed both locally in terms of developing and prioritizing projects in the non-recurring maintenance and minor categories as well as also using it in our planning for major construction. In addition, it is a major component or input into our facility development planning process.

Mr. **HAMMERSCHMIDT**. Thank you very much, Mrs. Livingstone. One more question, then, Mrs. Livingstone.

What is the actual condition of the 223-bed nursing home in Pittsburgh? Could it be renovated instead of being replaced by a completely new unit?

Mrs. **LIVINGSTONE**. Mr. Hammerschmidt, I will ask Mr. Jerry Neumann to respond to that. My understanding is that those beds are in very antiquated space and that the replacement is critical to meet modern and JCAH standards, but I will ask Mr. Neumann to respond in more detail.

Mr. **HAMMERSCHMIDT**. Mr. Neumann?

Mr. **NEUMANN**. Mr. Hammerschmidt, the very capital facilities studies that you spoke of showed or confirmed our findings that we should not be attempting to remodel those facilities. They need so much that a replacement is a much more economical and sensible solution, and our capital facilities study confirmed this.

Mr. **HAMMERSCHMIDT**. Thank you very much.

Mr. MONTGOMERY. We will go in order even though some members got in just after the gavel went down. Mr. Claude Harris is recognized.

Mr. HARRIS. Thank you, Mr. Chairman.

Mrs. Livingstone, according to the Booz Allen Hamilton study of three years ago, the VA was advised to make changes in the core process for recommendations, and I would just like to ask you, how has your office implemented these changes?

Mrs. LIVINGSTONE. Mr. Harris, with respect to the VA's implementation of the core process recommendations in the Booz Allen Hamilton study, the most significant finding in that study was that the VA's upfront planning required substantial improvement. As you know, we have initiated pilot test sites for a facility development planning process which is nearing completion, and we are in the process of bringing on board a consultant team which will be Booz Allen and RTKL to assess our pilot facility development planning process before contracting for the additional FDP's.

These FDP's, facility development plans, have been funded both in fiscal year 1987 and fiscal year 1988, and we are requesting an additional $10 million for an additional 40 FDP's in our fiscal year 1989 budget. So, we hope to be able to do something on the order of magnitude of about 120 of these with the funding that has been requested thus far.

In terms of the other Booz Allen core process recommendations, we have taken a number of steps. Some of those have been summarized in my formal testimony that has been submitted for the record.

We have, with the fiscal year 1988 advance planning fund list, for instance, extended what we used to call our preliminary plans to what will now be equivalent to 35 percent of working drawing. This greater level of detail will allow us to resolve functional and scope issues much earlier in the design process.

We also have a group that is working to refine, update and automate our space planning criteria which was another issue that was raised by Booz Allen. We are working closely with the Department of Medicine and Surgery to articulate more clearly the operating modalities upon which those criteria are based so there is very clear understanding of the functional basis for the actual space criteria that have been provided in our chapters. We have a manual which is called HO8-9 on space planning criteria.

We have also been working very closely with the Department of Medicine and Surgery to better integrate the MEDIPP planning process, the Medical District Initiated Program Planning Process, with our overall construction process. Dr. Gronvall may wish to address some of the recent changes that have been made.

There has been a major effort to refine and update MEDIPP, sort of a MEDIPP-II, I guess, that is coming to fruition which will much more closely integrate the MEDIPP planning process with our construction planning.

In particular, the Department is also providing for consideration of out of cycle MEDIPP recommendations that may have impact on construction decisions.

In addition, we have added to the Booz Allen core process recommendations in terms of revalidating our major construction projects at every critical milestone in project development. This, again, takes the project as it goes through a course of time, maybe three or four years, in the development process and rechecks it against the latest MEDIPP data to ensure that those projects are still reflective of the need and reflects work load data that are the most accurate that we have to date.

Mr. Neumann and Dr. Gronvall may wish to address additional actions we have taken.

Mr. HARRIS. Dr. Gronvall?

Dr. GRONVALL. I really would have little to add, because I think that is a very good comprehensive summary.

Our program planning process in the Department of Medicine and Surgery has been refined, as Susan Livingstone said, and specifically focused to more directly and automatically be translated into facility needs, and we have worked very closely with the Office of Facilities to ensure that our program planning comes first. Once the program plans have been approved, the overall plan can be quickly translated into the facility needs at every one of our medical centers and clinics and nursing homes.

Mr. NEUMANN. I would only add that the real objective of the recommendations by Booz Allen was that we should be able to produce our product faster. The two key recommendations having to do with the revision of our internal process as well as the development of the FDP plans for each facility are intended to save developmental time on the project.

We have a goal of one to two years in time savings as we bring the facility development plans in and revise our internal operations.

Mrs. LIVINGSTONE. Mr. Harris, I might also mention that we have developed a project management plan approach, and I would ask Mr. Neary to respond specifically to the Booz Allen recommendations.

Mr. NEARY. One of the recommendations by Booz Allen was that we implement some process control improvements. In that area, we have identified and have begun using what we refer to as project management plans, plans which at the outset of project development articulate the milestones, participants in the process, time frames, et cetera, and we track against these plans to mark our progress so that we are aware when slippage is occurring.

I might also say that during the course of the Booz Allen study, at the direction of the Congress, the VA was involved in developing an improved and quantifiable prioritization methodology for major construction. Booz Allen included in their report recommendations that we continue on and finalize something of that nature, and we have done so.

For two years, we have been using this methodology. We feel that it very effectively compares projects and evaluates their priority against key characteristics which we believe are important.

Mr. HARRIS. Could I have an additional minute, Mr. Chairman, for one more question? I didn't realize I was going to get so many answers.

Mr. MONTGOMERY. Certainly.

Mrs. LIVINGSTONE. Booz Allen made a lot of recommendations.

Mr. HARRIS. Dr. Gronvall, several observers have suggested that a formula be developed for modernizing the VA medical facilities. For example, with 172 hospitals and a 30-year life cycle, one could say that 5 or 6 hospitals would have to be modernized in each year.

Maybe that is too simple, but I would like to know your view of the idea of some sort of formula or plan for updating and modernizing our facilities.

Dr. GRONVALL. I can give a general answer to that. As we have looked at the needs of our total hospital system, we would agree that something like that level of complete modernization or replacement projects each year would be desirable and appropriate in a general way in relation to the issue of obsolescence of hospital facilities.

What has happened each year is that we have looked at the actual financial impact of doing four or five or six modernization/replacement projects but by the time the budget is reviewed in terms of all of the priorities for things that need to be done both in the operating budget and the construction budget, the final decisions on the President's budget have ended up being short of that level of proposed replacement or major modernization projects.

However, projects have been proposed on a budget priority basis as is always the case when you get around to preparing an actual budget request.

We have tried very hard to ensure that our on-going maintenance, repair, and upgrading of facilities is of good quality. So, even many of our old facilities are, in fact, very well maintained, and they were built as very solid facilities at the outset.

The problem in those old facilities is that the old buildings were functionally planned in a different era and do not accommodate modern medical technology. So, that imposes limitations in the hospitals.

Mr. HARRIS. Thank you, Mr. Chairman.

Mr. MONTGOMERY. Thank you.

Mr. Staggers.

Mr. STAGGERS. Thank you, Mr. Chairman.

I have two specific questions, and I will get into some more general ones if I have time. Like my colleague, I may have more answers than I have bargained for.

The first question I have is on the clinical improvement project at Beckley. From talking to people down there, it appears that they are satisfied. Is that pretty much going to meet the needs of that community in that area?

Mrs. LIVINGSTONE. Mr. Staggers, that will meet the requirements of the medical facility in terms of its clinical addition. As you know, there is a fiscal year 1989 budget request for that project, and we hope to make the working drawing award, the final design award, for that project next month. So, we will be moving forward expeditiously.

That is a project, I might note sort of editorially, that has been able to be expedited by the design fund line item that Congress set up several years ago. If we had not had the availability of that line item, we would have had to wait until next October to award the working drawing design.

Mr. STAGGERS. With the new home care unit replacing the nursing home unit in Pittsburgh and going from 228 beds to a 240-bed nursing home care unit, I have to believe that is not going to be enough. I could be wrong, but do you think that is enough for the needs of the community?

Mrs. LIVINGSTONE. I believe the project was scoped in accordance with the projection of need for nursing home care. Clearly, as you know, we have been reassessing the mix of VA provision for nursing home care, and the project at Pittsburgh was developed on MEDIPP projections for nursing home care at that facility.

It is increasing the beds, as you noted, by about 12 overall, and I believe that was just reflective of what the MEDIPP requirements were for that project at that time. That is not to say that in the future, additional beds might not be needed.

Mr. STAGGERS. Are you saying that this is based on right now and we are not projecting demographics?

Mrs. LIVINGSTONE. No. We do project to the future, but the scope of that project initially would have reflected what the requirements were for the project to the year 2000, and I believe it was 240 beds. I don't know if Dr. Winship or Dr. Gronvall wish to add to that.

Dr. WINSHIP. If we look at the 240 beds as being the only nursing home beds available for Pittsburgh, that would be true. However, we also extensively use community nursing homes and will continue to do that as well as the State veterans' homes in Pennsylvania.

It is correct that the planning does project for out years, but an important feature of the planning is what the history has been. If that history changes and projections need to change, it is conceivable that more beds will be needed in the future.

We believe on the basis of our best judgment, though, at the present time that the 240 bed facility will serve the needs of that hospital adequately.

Mr. STAGGERS. I guess that brings me up to my general questions. It strikes me that we are somewhat backwards in looking at the history and not looking at projects. On page 11 of your prepared statement, you say, "I would like to note that needs based planning is the cornerstone of the VA facility planning program."

Are we looking at the demographics or are we looking at the future or are we looking at budget constraints?

Mrs. LIVINGSTONE. No, Mr. Staggers. When projects are developed, they are based on the latest MEDIPP projections in terms of work load. We put together what is called a data package. Currently, workload is projected to the year 2000. In the next MEDIPP cycle, it will be to the year 2005.

Mr. STAGGERS. I guess one question I have is, how many of the FTEE in the Office of Facilities are devoted to translating construction requests?

Mrs. LIVINGSTONE. Translating the construction request?

Mr. STAGGERS. Or the needs based planning. I guess not only in Facilities but also in the Department of Medicine and Surgery.

Mrs. LIVINGSTONE. In terms of the Department, I would let Dr. Gronvall respond to the MEDIPP portion of this. In terms of the Office of Facilities, essentially, we are in the project development business, and one could say, technically, that everybody who works in the Office of Facilities is in the process of developing and readying and designing and constructing projects.

In terms of our staff size for the Office of Planning and Development, Mr. Neary can provide that figure. That is the staff that handles the up front planning portion and readies the projects for actual design and construction which are then accomplished by our Project Management Service.

Mr. Neary?

Mr. **Neary**. The Office of Planning and Development within the Office of Facilities has an FTEE level of 73. In addition to our own personnel, we work in conjunction with the Office of Project Management. Individuals in that office, project managers, are responsible for the specific project development activities.

The Office of Facilities also retains architectural and engineering firms to support the VA. Personnel from the Department of Medicine and Surgery both in Washington and at the field facility level also participate in the process.

Mr. **Staggers**. What about with the medical?

Dr. **Gronvall**. Mr. Staggers, I don't have an exact FTEE figure of how many people in the Department of Medicine and Surgery are engaged in planning. We could supply a more detailed answer for the record.

[Subsequently the Veterans' Administration furnished the following information:]

The number of FTEE in the Department of Medicine and Surgery engaged in needs based planning as their primary responsibility is 50 in regional and medical district offices and 43 in the Office of Strategic Planning in VA Central Office.

However, in each of medical districts—and we have 27 medical districts across the country—we have at least one planner who is working full time. In each of our seven regional directors' offices, there is at least one planner.

Mr. **Staggers**. That is with needs.

Dr. **Gronvall**. Correct. This is all focused on program planning based on veterans' needs for care projected into the future.

Then, in the central office, we have a strategic planning office, and, again, I would have to look up the number of FTEE.

Beyond the list of people that I have just given which adds up to something like 100 people working full-time on planning including both field and central offices, we have many other people on our staff who are actively involved in planning—our medical center directors, associate directors, chiefs of staff, many of our physician staff members. Many of those work on planning committees, planning boards, and devote a good deal of their time to planning and trying to project what the medical needs of each of our facilities will be.

We have, then, a considerable number of people assigned full-time as staff planners plus the support of many other people, basically the administrative and clinical leadership of our medical centers and our central office, engaged in planning activities to project future needs.

I think you would find, on very close scrutiny, that we have done a good job in maintaining accurate information about the projected demographics of veterans. That is done in an office that reports to the Administrator.

We use all of those projections, coupled with our actual experience of the proportion of the veteran population actually coming to the medical centers for care and project that experience into the future as a baseline and then translating that into the future program plans.

Mr. **Staggers**. This may be unfair, but does this committee have access to the needs information that is given to the Director or whomever?

Dr. **Gronvall**. Yes, completely.

Mr. **Staggers**. Mr. Chairman, I would ask unanimous consent just for one more quick question?

Mr. **Montgomery**. Sure.

Mr. **Staggers**. I appreciate that.

What is the status of the commuter assistance design, the CAD software program usage in the Office of Facilities?

Mrs. **Livingstone**. That was initially procured, as the committee may recall, for support of our nursing home care unit prototype which was ultimately approved by the Administrator last February, 1987. The prototype and the procurement of the CAD system were predicated on a very large nursing home care construction program that had been previously projected by the VA.

With the change in the mix of delivery of that care, we have had fewer nursing homes that have been coming on line through the budget process. We are using the CAD system primarily for other uses in the Department of Memorial Affairs and the Department of Veterans' Benefits and for some of our major construction projects.

I will ask Mr. Neumann to elaborate just briefly on that.

Mr. **Neumann**. On selected projects, we are using it for planning in the front end and as a teaching tool as we know the technology is improving and we wish to keep current state-of-the-art equipment and technology. We are looking for additional CAD applications as we move into our new process. So, I think we will utilize the CAD system to the fullest extent.

Mrs. **Livingstone**. Mr. Staggers, in specific response, the actual software program you are referencing was to be developed in support of our prototype nursing home. That software package has not been developed, because it is a rather expensive process to go through, and the VA is trying to determine whether it is cost effective, given the size of the nursing home care program that we have, to undertake that effort in lieu of just using our standard approach with architect/engineers.

That decision has not yet been fully reached. However, in the interim, we are using the CAD system for alternative uses.

Mr. **Staggers**. Thank you.

Thank you, Mr. Chairman.

Mr. **Montgomery**. Thank you, Harley.

Dr. Rowland.

Dr. **Rowland** of Georgia. Thank you, Mr. Chairman.

Mrs. Livingstone, I notice in your prepared statement that you did not mention the Veterans' Administration medical center in Atlanta. Would you say something about that, please, what the situation is there?

Mrs. Livingstone. Dr. Rowland, as you may know, the Atlanta clinical addition project is in the fiscal year 1989 budget for construction, and we are very pleased to be moving forward with that project. We anticipate making an award for working drawings on that project in May of this year, and we will be moving forward with the project which includes a parking structure as well.

The parking structure is about $9 million, and then the actual construction request for the facility is $54.2 million for that project. So, that project is moving forward.

Dr. Rowland of Georgia. How many beds are we talking about?

Mrs. Livingstone. That facility is currently projected at 506 beds.

Dr. Rowland of Georgia. I guess I want to talk to you, Dr. Gronvall, a little bit about that, because I want to talk about it more from the standpoint of the medical care that is going to be provided there, and I guess that is the reason I really want to talk with you.

In looking at what has taken place over the past few years there, the MEDIPP model in 1983 recommended 541 beds. In 1984, that recommendation was increased to 692 beds. Subsequently, the region proposed in the revalidation process 675 beds. Then, DM&S recommended a level of 623 beds, and OMB reduced that number to 506 beds.

Presently, there are 604 beds, so we wind up with 98 beds less than what currently exists there.

In looking at what has taken place, it seems to me that there hasn't been very good coordination between the construction aspect and the Department of Medicine and Surgery. It seems to me that DM&S may not have been involved as much as I think they should have been involved in making projections about what bed levels ought to be.

As I understand it, it was about a year and a half ago that DM&S and Construction were separated, and I just wonder how well that is working now.

Then, of course, OMB came along with a formula that they had and said to disregard everything after the 1983 MEDIPP, and we are going to take a formula and apply it to all of the hospitals based on nationwide findings. Since there is a reduction of 6.5 percent, we are going to take 6.5 percent of 541 and reduce the beds even further.

I have a good bit of concern about some type of formula that addresses the whole country and doesn't address a particular area. It kind of reminds me of a situation that recently happened in my district.

Georgia probably raises more turkeys, I am told, than any other State in the Union, but there is no turkey processing plant anywhere in the area, and these turkeys all have to be transported to North Carolina to be processed. Well, we tried to do something about this, because there is an organization that wants to establish a turkey processing plant in my State where they are raising the turkeys.

Since we have an over-supply of turkey processing plants nationwide, we can't get one in Georgia. It is kind of ridiculous to me. So, there is the additional cost of having to transport all these turkeys, and it looks to me as if we have sort of a turkey situation here in trying to apply a formula based on nationwide findings to a particular area.

Are you satisfied—Dr. Gronvall, you and I are concerned about the medical aspect of it. That is what I am really concerned about, and that is what you are concerned about, I know. We are talking about the changes that are going to take place in establishing a neurology bed section in Atlanta and the additional AIDS patients that will be taken care of, and we are talking about the conversion of the cardiac surgery program from a contract basis to an in-house program and the establishment of a PTSD psychiatric treatment unit.

That hospital is in a metropolitan area of around 3 million people, and I just find it difficult to understand why we are getting a reduction in beds. I just don't understand all of this going on.

I would like you to—my time has already run out and I haven't even asked my question—

Mr. MONTGOMERY. Go ahead, Dr. Rowland.

Dr. ROWLAND of Georgia. Could you give me some idea about your feelings about what has taken place there?

Dr. GRONVALL. I would be happy to do so, Dr. Rowland.

Your recitation of the steps leading to the current state of affairs is, to my knowledge, exactly accurate in the sequence of events. I have two comments, though.

I don't believe that the administrative restructuring of the Department's Facility Planning Service into the Office of Facilities had any immediate or direct impact on the flow of decisions about the Atlanta project.

The final decision as to the 506 bed level, which is the basis upon which planning has proceeded during this past year, was a decision that was made during the preparation of the 1988 President's budget. The application of the nationwide formula which resulted in down-sizing not only the Atlanta project but a number of other projects a year ago was applied during the final stage of executive branch negotiation and deliberation that led to the creation of the President's budget.

We in the Department felt at the time that the application of that kind of a nationwide formula should not countervene the detailed planning that had gone on for months and years prior to that time. That prior planning was based on a bed sizing model that had been developed by the VA in collaboration with the General Accounting Office to which some specific projected additions were made based on individual clinical determinations of specific needs for Atlanta.

So, that matter was one of intensive deliberation and appeal and discussion in the final preparation of the budget. So, that decision was made. The projection was made in the President's budget, and planning has proceeded along that basis.

Dr. ROWLAND of Georgia. Do you think that is adequate, Dr. Gronvall, for the Atlanta area?

Dr. GRONVALL. Adequate, of course, is a judgment word. The number of beds for which we are currently planning is clearly some 100 below the level that the Department had projected as the desirable or ideal or appropriate projection of bed need in that facility.

Dr. **Rowland** of Georgia. Well, I am pleased that you agree with me.

[Laughter.]

Dr. **Rowland** of Georgia. Thank you, Mr. Chairman.

Mr. **Montgomery**. Dr. Rowland, when you preside, you can come back for some more questions.

Dr. **Rowland** of Georgia. Thank you, Mr. Chairman.

Thank you, Dr. Gronvall.

Mr. **Montgomery**. Before recognizing Mr. Penny, I mentioned to several members—and some were not here—that I had the privilege of being in Minneapolis with Congressman Penny, a member of this committee, and went to the new VA hospital facility in the Twin Cities/Minneapolis. It is a terrific facility, and I would encourage members of this subcommittee when you have the time or take the time, to go out and look at some of these hospitals around the country. If you get a chance, the committee would like you to go up to Minneapolis where we have the finest hospital in the world right now, and it is a VA facility.

Mrs. **Livingstone**. Mr. Chairman, if I could add, that project also was brought in on time and under budget as well.

Dr. **Gronvall**. And, Mr. Chairman, I would like to add my comment to that as well. I have been there several times. It is a wonderful facility. As Mrs. Livingstone said, it was brought in on time and under budget.

It does represent a very creative partnership between the medical people in the Department of Medicine and Surgery and our Office of Facilities to translate the local needs into a facility that is well adapted to the climate and environment of Minneapolis. So, it represents a real success in the planning process that has been a matter of so much discussion here today.

Mr. **Montgomery**. Mr. Penny.

Mr. **Penny**. Thank you, Mr. Chairman.

First of all, I do appreciate your visit to Minneapolis this last weekend. It is important to have our facility and our staff up there recognized by this committee and its chairman. It will long be remembered that you came and showed some special interest in the new hospital in Minneapolis.

As the chairman mentioned, it is an impressive facility. It appears to us that almost anything in terms of modern day medical care that a veteran could need is going to be available at this facility.

We were also impressed to learn that the local staff initiated many of the specifications for this facility. I don't know how that tracks with the normal planning process, but it does seem to me that with that local input which was then translated into a design, they now have a facility that is going to be more functional, more efficient, and more suited to the needs of our veterans up in Minnesota and the surrounding region.

I would hope that if it isn't common for the VA to let the planning begin at the local level that they have demonstrated the success of this effort in Minneapolis and that local involvement would become the norm within the VA from now on.

Dr. **Gronvall**. Mr. Penny, if I may, that is exactly our policy and procedure and intent in every project that we work on. In some, we fully accomplish that, and I think Minneapolis is a good example. In other places, we fall short of that, but that surely is our desired objective.

Mr. **Penny**. Well, I would suggest that the evidence is that it has worked so well in Minneapolis that if you can model the approaches of the other planning processes after the approach that was used in the Twin Cities, you will probably find it successfully replicated around the country.

Dr. **Gronvall**. Let me add one other kudo, if I may. You have complimented the VA staff, and I should say that we had a great deal of assistance from the veterans' service organizations in the Twin Cities area and local people, community groups, and that provided support and assistance. Some of that led to a spectacular statue that has been created outside the medical center with local support, again, that put the cap stone on all of that planning as an excellent facility.

Mrs. **Livingstone**. Mr. Penny, if I might add, I fully concur and agree with the remarks that you made with respect to the planning approach utilized at Minneapolis. Indeed, as Dr. Gronvall said, we would hope that would be the model for our facilities nationwide.

The Minneapolis project worked so well that we did send a special team there to actually interview those involved with the project and document the processes there. That report is in the final stages of being completed, and we are going to be sharing that report system-wide with all medical centers and folks involved in the project development process as an example of exactly the steps that were taken that led to the type of success that we had in Minneapolis, which included the medical center director very, very actively involving numerous individuals on his staff.

So, again, there was a tremendous participatory aspect to that project with the senior resident engineer and his staff, the medical center staff, the Office of Facilities, DM&S central office, the district and regional folks working as a team, and it did work immensely well. We are doing an actual report on it as a model for others to follow.

Mr. **Penny**. Thank you. I am pleased to learn that.

I also know that it came in well under budget. That doesn't happen often enough in government programs and projects, and I would like to think that the planning process and the way in which this project was undertaken, with the cooperation that was involved, had something to do with getting it done on time and for less money. It is a fine project for the money spent. It is amazing how much you can get for the dollar. That is another model that I hope can be replicated throughout the system.

I don't see in your request any indication of replacement hospitals. Is there something coming in the future? There is certainly no start-up or replacement hospital in this budget. You have some renovations and additions but no major new hospital construction is in the up-coming year's budget.

Are we looking at new construction somewhere down the line?

Mrs. **Livingstone**. In terms of total replacement?

Mr. **Penny**. Total replacement, yes.

Mrs. **Livingstone**. As in Minneapolis.

Mr. **Penny**. I see some partial replacements here.

Mrs. LIVINGSTONE. Right. We have four projects either in design or construction in the replacement/modernization category in the fiscal year 1989 request. Again, while they may not be total replacements, in not all cases is a total replacement necessary to meet the functional deficiencies or corrective action required, but we do have a number of replacement hospitals in the pike, so to speak, including one at Reno.

There is another that is not a total replacement, but, again, the Dallas clinical addition and spinal cord injury center is a very high priority for the Veterans' Administration. We are also planning construction of a 290-bed psychiatric facility in Gainesville, Florida.

So, there is a number of very large replacement/modernization projects that are scheduled for the future.

Mr. PENNY. Mention of Gainesville touches on the one last question I had, and that is that in the 1989 budget, I don't see much going on down in Florida. Since Congressman Mica isn't here this morning, I was just going to ask how it is that the State with the fastest growing population of veterans is seeing so little happen in the fiscal year 1989 construction budget.

Mrs. LIVINGSTONE. Mr. Penny, I might note that the State of Florida has received a great portion of construction funding in the past, and we did include, as you know, the Tampa nursing home care unit in the fiscal year 1989 budget. We also are in the process of utilizing design funds that were previously provided by Congress for the design of a new 173rd VA medical center in Palm Beach County, Florida.

So, these projects are in the works as well as the Gainesville 290-bed psych facility which is scheduled for fiscal year 1990 consideration. We are also looking at the construction of a 120-bed nursing home and 30-bed spinal cord injury center in Gainesville for future construction, and there have been a number of new satellite outpatient clinic activities in the State as well.

So, it is no ill reflection on the State of Florida in terms of the fact that we only have one project for the State in the fiscal year 1989 budget. Basically, it was reflective of our priorities as presented during the executive review of the 1989 budget, and we have done a lot in the past, and we are planning on doing a lot more construction in the future in that State.

Mr. PENNY. Well, I expected that there would be an answer of that nature. I expected that there was more going on in the past and in the future and that this was maybe just kind of year in which the money didn't actually need to be spent but that other things were going on. I appreciate your elaborating on that.

Thank you, Mr. Chairman.

Mr. MONTGOMERY. Just a brief answer will take care of one of the questions I have.

What are the current planning activities in the Navy and Air Force regarding the new hospital in the general area of Brevard County, Florida?

Mrs. LIVINGSTONE. Mr. Chairman, the VA is currently in the process of determining what we call the delineated area which are those site boundaries in which we would start searching for specific sites and then do an environmental impact assessment of them for a potential new hospital in east central Florida. The delineated area has not yet been established for that project. As soon as it is—and we hope that will occur in the near future—we will be advertising to hire an architect/engineer to assist us in initial development of that project.

Mr. **Montgomery**. Are you planning on a sharing agreement, I guess is what I am working to, with the Air Force?

Dr. **Gronvall**. Mr. Chairman, yes. We are working with both the Navy and Air Force reviewing the program at the Orlando Naval Training Center and then at Patrick Air Force Base to ensure that whatever happens to the final decision about an east central Florida hospital, we, from the outset, will be closely working with and entering into sharing agreements with both the Navy and the Air Force.

That deliberation and discussion is on-going.

Mr. **Montgomery**. We really think that is the way to go—a sharing agreement between the VA and the military. It would help both groups, ours and also the military health facilities which are really having their problems at this time.

John Bryant of Texas.

Mr. **Bryant**. Thank you, Mr. Chairman.

Dr. Gronvall and Mrs. Livingstone, you have answered a number of questions here today in terms of priorities and prioritization methodology. In the March 2 hearing when I asked about the construction project for the Dallas Veterans' Administration medical center, you answered me in those terms as well.

I recall that Mrs. Livingstone talked of the VA construction projects in terms of priorities and said the OMB funded the projects for the VA in the order of the priorities that the VA presented in its budget submission to OMB.

The question I want to ask about today is not only related to the Dallas project which, of course, is of special interest to me, but also to your prioritization methods in general. The construction project for the Dallas Veterans' Administration medical center has been number 10 on the VA's list of top ten medical centers judged most in need of construction, replacement, or major modernization since fiscal year 1985. It was included in the five-year medical facility development plan for fiscal year 1985 through fiscal year 1989 and has been included in each five-year plan since then.

Another project mentioned just a moment ago for Gainesville, Florida has been on that list since fiscal year 1984. Yet, the VA has never submitted a budget including these projects.

In your five-year medical facility development plan for fiscal years 1988 through 1992 two new construction projects for Newington, Connecticut and Indianapolis suddenly appear, I believe, for the first time. They had not been on the list of the top ten most in need, and, I believe, they had never before been in the five-year medical facility development plan.

Yet, your budget requests funds for these two projects in 1989 and did not request funds for either Dallas or the psychiatric facility for Gainesville.

I would like to ask you what kind of a prioritization methodology allows you to suddenly appear with two construction budget items that leap ahead of two others that have been on the list for a very long time.

Mrs. **Livingstone**. Mr. Bryant, I may ask Bob Neary in a moment to elaborate on this, but the Dallas and Gainesville projects were first added to what we call the list of ten projects most in need of replacement or modernization prior to the formulation of the VA's prioritization methodology which came on board in February of 1986. The methodology was first used in the formulation of the VA's fiscal year 1987 submission to Congress.

Unfortunately or fortunately, depending on how one looks at it, that prioritization methodology did result in some reordering of priorities once it was established in terms of the scoring. That does not lessen the fact that Dallas and Gainesville are still very high priorities, but Newington and Indianapolis were higher priorities based on that methodology.

Mr. **Bryant**. When did they first appear on your list?

Mrs. **Livingstone**. The Newington and Indianapolis? I believe they appeared first in the June 30, 1987 list that was just submitted to Congress last summer.

Mr. **Bryant**. Could you give me an exact answer? I would like you to be sure about that. Are you sure about that?

Mr. **Neary**. Yes. They appeared in the Medical Facility Development Plan but were not included on the list of ten. This past June 30 publication included them on the list of ten.

Mr. **Bryant**. I would like you to explain to us, if you would, how your prioritization methodology works.

Mr. **Neary**. I would be happy to, Mr. Bryant.

The Veterans' Administration for many years was severely criticized for what was viewed as too heavily judgmental prioritization of major construction projects. In the 1985 appropriation bill, the VA was directed to develop a methodology which, to the fullest extent, would be quantifiable.

The VA did that in consultation with the staffs of the four committees of Congress that we deal with and with the Office of Management and Budget and implemented it, in early 1986. It works this way:

There are various kinds of construction projects, and they have characteristics sometimes much different from one another—an electrical project versus a replacement hospital versus a nursing home. So, a weighted system has been developed for each kind or category of construction project that, by answering a series of data based questions and a series of judgmental questions, produces a score.

In the case of the judgmental questions, a panel of raters is established, and those raters are asked to express their judgment about these key indicators—

Mr. **Bryant**. This is a panel of writers?

Mr. **Neary**. Raters.

Mr. **Bryant**. Oh, raters.

Mr. **Neary**. Those scores then are averaged and produce a score, the highest possible score being 10 for each category.

Mr. **Bryant**. Now, what is a judgmental question?

Mr. **Neary**. One judgmental question would be the extent to which you believe this project would improve the quality of care delivered at a medical center.

Mr. BRYANT. That is hardly a specific question. That is the whole focus of this subcommittee. That doesn't sound like something you could rate or reduce to a numerical objective categorization.

Mr. NEARY. We hope that by using a panel of individuals at the field facility and in the central office to bring in a quantifiable way what is a very difficult thing to quantify.

Mr. BRYANT. Well, is that the only judgmental question?

Mr. NEARY. No, sir. In each category there are two or three kinds of questions. We would be happy to provide you with a copy of the methodology.

Mr. BRYANT. Well, you say in each category. What kinds of categories are there in which you get to answer judgmental questions?

Mr. NEARY. In the categories of patient privacy, environment of wards, the risk aspect of fire safety projects.

Mr. BRYANT. Those are judgmental questions. What are the other kinds of questions that you mentioned?

Mr. NEARY. More fact based or questions that are answered by a piece of data, for example, has the facility been modernized in the past ten years? The Office of Academic Affairs has a system of rating university affiliations—whether they are considered major affiliations or minor affiliations.

Mr. BRYANT. It sounds to me like the judgmental questions are basically conclusions. You ask this group of raters to reach a conclusion. Isn't that right?

Mr. NEARY. We are asking the raters to express their judgment on the factor in question.

Mr. BRYANT. Who are the raters?

Mr. NEARY. Who are the raters?

Mr. BRYANT. Yes.

Mr. NEARY. The raters include an individual designated by the director of the VA medical center, often the director.

Mr. BRYANT. You say often the director. What do you mean?

Mr. NEARY. The medical center director personally will often participate. Most of the time, he will participate. A representative from the Department of Medicine and Surgery's regional director's office, the Department of Medicine and Surgery's Strategic Planning Office, the Office of Facilities, and the Office of Planning and Development are others.

In the case of a technical project, we would involve professionals in the individual discipline such as electrical or fire safety.

Mr. BRYANT. Do these people ever have a conversation with the leadership of the VA about what outcome the leadership of the VA would prefer to see before they go down there and do their judging?

Mr. NEARY. Maybe I should answer that by describing the second part of the methodology. The leadership of the VA met and, during the course of a modified delphi exercise, expressed judgments as to how each category affects the overall mission of the Veterans' Administration and established what we refer to as an agency emphasis weight.

As I mentioned, each category of project can potentially get a score of 10. Then, an emphasis weight is applied to that which, in a sense, is a boost. The largest emphasis is a 90-percent increase for nursing homes. Then, for the other categories, there are other emphasis weights applied.

That produces a final score, and it is the final score, then, that establishes the priority. The individual raters, certainly not as part of their rating experience have any conversations with agency management about what they would like to see as the outcome.

Mr. **Bryant**. Is all of this reduced to writing?

Mr. **Neary**. Yes, it is, sir. I would be very happy to provide it.

Mr. **Bryant**. Does our staff already have that? If not, I would like to ask that you submit that whole process to committee.

Mr. **Neary**. It was provided to the committee two years ago when it was developed. We would be happy to provide you with copies again.

Mr. **Neumann**. Or we could arrange to brief you.

Mr. **Bryant**. You say you have or have not provided us with the—

Mr. **Neary**. Yes, sir, we have.

Mr. **Bryant**. Further refinements. You have?

Mr. **Neary**. We have provided the methodology, yes.

Mr. **Kanjorski**. Would the gentleman yield?

Mr. **Bryant**. Sure.

Mr. **Kanjorski**. I would certainly like to have a full copy of that, and I would like to be briefed on it.

Mr. **Montgomery**. Thank you, John.

Mr. **Neary**. We would be pleased to do that.

[The material to be supplied appears on p. 61.]

Mr. **Montgomery**. Mr. Kanjorski.

Mr. **Kanjorski**. Mr. Chairman, I guess I hear my voice reverberating in the chamber, because way back in May of 1985, this committee authorized the construction of a 60-bed nursing home at Wilkes-Barre, Pennsylvania. We had appropriations for that facility. Specifically, in 1988, after a lot of delay and comments from the VA that they had decided that it wouldn't go under construction until 1993, we authorized design money of $330,000 in fiscal year 1988.

Mrs. Livingstone, will you tell me what the status of that project is presently?

Mrs. **Livingstone**. Mr. Kanjorski, the Wilkes-Barre nursing home has been added to that list of projects that will be utilizing our fiscal year 1988 design fund monies. We are scheduling or targeting a working drawing award for that project in July of 1988. That award will be using the fiscal year 1988 design fund money.

Mr. **Kanjorski**. Now, does that indicate that since the design will be completed sometime in 1988 that appropriations available in 1989 will be utilized for that project, or do you intend to put that off and just design it and delay it as you originally indicated?

Mrs. **Livingstone**. Mr. Kanjorski, with the working drawing award made in July of 1988, the working drawing contract itself probably would not be completed until about July of 1989. So, the earliest the project could be considered for construction funding would be in the fiscal year 1990 budget horizon.

However, I believe as we have testified previously before the committee, in conjunction with the committee's direction, we put forward for budget consideration those projects in our priority order, and the Wilkes-Barre nursing home, while a priority, is not among the top priority considerations for nursing home care units in fiscal year 1990.

So, it would not be in the fiscal year 1989 budget request for the VA.

Mr. KANJORSKI. In other words, you are telling me that in spite of the fact that we are going to design it, you are still going to carry on your policy of not building it until you want to get around to building it. Is that correct?

Mrs. LIVINGSTONE. Well, Mr. Kanjorski, I think the VA in some respects is sort of between a rock and a hard place.

Mr. KANJORSKI. Let's correct the hard place. What does this committee have to do to get that building built?

Mrs. LIVINGSTONE. The VA will not be making a request for construction funding for that project in fiscal year 1990.

Mr. KANJORSKI. If this operating committee orders you to make that request, you still won't make that request?

Mrs. LIVINGSTONE. No, sir. If the monies are specifically appropriated for that project, we will construct it.

Mr. KANJORSKI. If we have money specifically appropriated this year for 1989 or 1990, you will construct it that year?

Mrs. LIVINGSTONE. Yes, sir, that is correct.

Mr. KANJORSKI. Now, I heard the prior discussion with some of our members here on this priority system. I have, Mr. Chairman, had the occasion to circulate around many of the hospitals in the VA system, and I intend to take your suggestion to do it a lot more often, because I think perhaps a little more hands-on oversight by this committee is necessary.

There are a lot of veterans' hospitals that have been ignored, and I don't understand the priority system of the Administration and how they improve these systems. I guess until it gets to be disastrous, this Administration won't open up funding to bring these hospitals up to date in many instances.

However, I know several hospitals in Pennsylvania. The one I am referring to in Wilkes-Barre, Pennsylvania has 16 patients in a room on occasions. I have been up there, and, I have rated that hospital and every other hospital in my district and in that area of Pennsylvania, and, quite frankly, I find the Veterans' Administration hospital to be in great need of repair and not up to date compared with any other facility in that area.

Fortunately, we have a great staff and a great administration in the facility, and they are doing everything they can. However, there have been commitments made along the line that this hospital was supposed to be renovated and up to date and a new facility added over the years, and, to my understanding, this is isn't on line. So, I would like to get some idea of what the priority on the renovation of the hospital is generally in that area.

Mrs. LIVINGSTONE. Mr. Kanjorski, some years ago the VA added to its fiscal year 1985 advance planning fund list the medical center modernization for Wilkes-Barre. It is currently targeted to be about an approximately $50 million project for that medical center, and we are hoping to have the project ready for consideration in the fiscal year 1992 budget horizon.

Mr. KANJORSKI. Is there anything this committee has to do in authorizing funds for design or any other category to move this along?

Mrs. LIVINGSTONE. I am not sure if the committee has yet authorized that project. I would have to check our authorization table on that, and we will respond to you for the record, or I will advise your office later today after I get back.

Mr. KANJORSKI. I would appreciate that.

Thank you, Mr. Chairman.

[The material to be supplied appears on p. 141.]

Mr. MONTGOMERY. Thank you very much, Paul.

Bob McEwen of Ohio.

Mr. MCEWEN. Thank you, Mr. Chairman.

Could you give me an update on the situation with the new cemetery in Ohio as to where that stands presently? Do you have information available?

Mrs. LIVINGSTONE. Mr. McEwen, we have Mr. Wil Ebel here who is our Chief Memorial Affairs Director. I might ask him to come up to the microphone and respond to your question.

Mr. MCEWEN. Thank you.

Mr. EBEL. We have in the fiscal year 1988 budget money for four EIS projects. One of them was Cleveland, and we are in the process now of a site selection board, and we will be moving out as fast as we can on the EIS.

Mr. MCEWEN. Can you describe the site selection boards to me as to how they function?

Mrs. LIVINGSTONE. The site selection board, basically, is composed of individuals from the Office of Facilities as well as the client department, in this case, Memorial Affairs. They travel out to an area, and basically take a look at the availability of potential sites for donation and/or potential purchase in the area.

They may also check on land values and obtain basic demographic and local data on the area.

Mr. Neumann, do you have anything to add?

Mr. NEUMANN. No, I don't. That is substantially how it works.

Mr. MCEWEN. Could I meet with them?

Mr. NEUMANN. Surely.

Mr. MCEWEN. Could you have them contact my office? I would like to discuss this.

Mrs. LIVINGSTONE. We would be glad to. The chairman of that committee, I believe, was just appointed a few weeks ago. So, we will be glad to do that.

Mr. NEUMANN. He is organizing his team as we speak.

Mr. MCEWEN. Thank you.

Some of the veterans' organizations later this morning will say that the VA simply does not have the proper information required to make these construction judgments. You have discussed how you came about coming up with the numbers. Some feel that it is just simply too narrow.

Do you have any comments you would like to make, recognizing that criticism will be there?

Mrs. LIVINGSTONE. Mr. McEwen, there are probably several comments I would like to make. One, I guess, at the outset, is just to recognize, as the committee recognizes, the very valuable role in both reviewing and overseeing the VA's work that the VSO's play.

I have read the testimony that reflected the concern about whether or not the VA has sufficient information to really formulate a needs based budget. Basically, it indicated to me that we have not adequately done our job in communicating to the veterans' service organizations exactly how our planning system works.

We do have a quarterly forum with the veterans' service organizations in which we do raise whatever topics they would like to discuss, and this is not one that has been specifically addressed as yet. I will make sure it is on our next agenda.

I have been at the VA since 1981. I came in November of 1981. We had innumerable planning tools in place during that time, but all of them have been significantly enhanced and improved over the years.

Planning, as everyone knows, is not a static type of tool. It is constantly being enhanced or refined or, as Mr. Neary was indicating, objectified. Those initiatives range from the development of the MEDIPP process on the medical program planning side to the development of our facility development planning initiative to our prioritization methodology.

I believe that there is a tremendous volume and wealth of data that we have had to assist us in our decision making processes over the years. That data and the reformatting and use of it are getting better every year.

I guess I would just say as a bottom line comment that I would take strong exception that the VA does not have a needs based construction program. I believe we do and that our planning system, while all planning systems can be improved, is improving, and I hope it will continue to improve in the future.

Mr. McEwen. I fully recognize your frustrations and encourage you to augment it with communication, because you certainly do not have sufficient resources to do what needs to be done.

Mrs. Livingstone. I think perhaps some of the concern that was expressed was with respect to the medical centers' individual five-year plans, and I think the terminology was used that it was a laundry list or something of that nature. As we have been discussing this morning, I believe there is probably no one who better knows the deficiencies and the problems of a medical center than the individuals who work in it, and those are the individuals who put together those five-year plans.

I don't view them as laundry lists. The ultimate projects that may come out may be different in terms of the approach selected for the correction, and the funding cycle may be entirely different than what was initially proposed by the medical center, but that is not to say that the deficiency still doesn't exist that was identified by the medical center.

A great deal of effort, I know, goes into the formulation of those five-year plans by our medical center personnel. They are taken immensely seriously. They are reviewed in our central office and adjusted accordingly.

One has to recognize that the medical center staff is looking only at their one medical center, and they do not have the perspective or benefit of system-wide priorities and other needs. So, that is why those plans do come into our central office and are reviewed by DM&S and Office of Facilities central office individuals who work with the medical center to again make more realistic schedules and funding projections with respect to those plans.

Mr. McEWEN. I have two quick questions.

Number one, how many nursing homes did you request originally through OMB?

Mrs. LIVINGSTONE. We have the Tampa nursing home care unit in the budget. In addition, we requested but did not receive funding for construction of a 120-bed nursing home care unit in Mountain Home.

Beyond that, we requested funding for the two other nursing homes that are in the budget for Pittsburgh and—

Mr. McEWEN. You requested four?

Mrs. LIVINGSTONE. It was Tampa and Pittsburgh—I am sorry.

Mr. McEWEN. And you got one.

Then, you make reference to the increases in construction over the last four years, a 57-percent increase in dollars. Naturally, someone is going to raise the question as to how much that means in real terms. You haven't figured that out without inflation, have you?

Mrs. LIVINGSTONE. Mr. McEwen, I believe that figure is around a 9-percent increase in real dollars. Mr. Neumann can confirm that.

Mr. NEUMANN. Yes, that is correct. It is a little under 10 percent in real dollars.

Mr. McEWEN. Let me suggest to you it could be significantly higher than that. I think you used the CPI. If you use the Consumer Price Index and do not use the Construction Price Index, you will get totally different figures. Let me just give you a quick figure.

In 1982, we authorized a bridge for $183 million. Due to the collapse in the construction industry during the 1980's, the costs of construction have gone down in many instances.

You talk about on time and under budget. Most construction sites are under budget, and we built that new bridge for $86 million as opposed to the $183 million that was appropriated by the Congress. We are going to get three more bridges out of that same amount of appropriated money.

So, construction costs have actually diminished. They are not the same, and I would encourage you to not take the CPI inflation factor and apply it to those dollars and presume that in real terms it has only gone up 9 percent. I suggest it may possibly have gone up more than that when talking about the construction budget.

Mr. NEUMANN. I thank you. We do use the Boeckh Building Cost Index.

Mr. McEWEN. All right.

Mr. NEUMANN. It reflects what you have described. I agree with you that the construction market has become fairly stable dollarwise.

Mr. MONTGOMERY. Thank you, Mr. McEwen.

Let the record show that Tim Johnson of South Dakota was here and had to leave, that Joe Kennedy of Massachusetts was here and had to leave, Congressman Bilirakis of Florida was here, Tom

Ridge of Pennsylvania was here, and Chris Smith of New Jersey was here.

On the job and staying here is Mr. Stenholm of Texas. The Chair recognizes the gentleman from Texas.

Mr. STENHOLM. Thank you, Mr. Chairman.

I want to pursue the line of questioning Mr. Bryant of Texas started concerning the rating system. It is an area in which we have become quite interested in the total health care field as well as specifically in the veterans' area.

You mentioned the ratings, the raters, the judgment, and the facts. I specifically want you to go a little further with me on the fact finding area, where you are making factual determinations rather than judgmental determinations.

You mentioned major affiliations with medical schools and then minor affiliations. Clarify for me what that determination is.

Mrs. LIVINGSTONE. Mr. Stenholm, I would like to ask Mr. Neary to expand on that.

Mr. NEARY. The level of affiliation is one of the many factors that are involved in the rating process, and maybe Dr. Gronvall or Dr. Lewis would like to comment. My understanding is the Department of Medicine and Surgery has a system of expressing numerically a judgment as to the level of affiliation, and that number is one of the ingredients.

Mr. STENHOLM. In plain English, what do you mean about level of affiliation?

Dr. GRONVALL. In plain English, that means the extent to which the VA medical center is an important component of a broader education and research effort through an affiliation with a medical school so that the other missions of the department, namely, education and research, are being enhanced by a construction project at a medical center that is affiliated as contrasted to one that is not affiliated and, therefore, has a narrower mission definition focused primarily or almost entirely on direct patient care.

Mr. STENHOLM. Now, in a formula that you have, you always weight things as to their level of importance.

I understand that, but can you help me with some specific definition of weighting that you might give to a particular institution in the affiliation level? What would be a higher weight example, what would be a lower weight, and how much weight in a formula are we talking about in this area? How important is major affiliation with a medical teaching institution? How much weight is given to that and the various aspects of that in prioritizing?

Mr. NEARY. I would have to provide that, sir. I can't recall within, for example, the clinical category the weight that is given that particular aspect versus the functional and physical relationships or the quality of care issue, if you will.

Mr. STENHOLM. I understand you are going to furnish the committee with the specific formula, but if you could provide me with just a basic understanding.

Mr. NEARY. My sense is that it is a relatively small factor on an individual project.

Another element that I refer to as a data answered question would have to do with existing space versus the space that our standards would suggest should be provided at a medical center to meet the work load. Another data answered question would be questions that indicate the number of beds that will be provided by the project in question.

Mr. STENHOLM. The major affiliation definition—medical school, proximity, cooperation, et cetera—would not be a major factor in the formula?

Mr. NEARY. Yes, sir. The most important factors in the formula, typically, are the age and condition of the existing physical facilities and the amount of space that is available to carry out the work loads that are there versus what we would expect should be there to meet those work loads?

Mr. STENHOLM. What about occupancy rates—utilization?

Mr. NEARY. They are not directly used in this methodology. They are indirectly used through the various program projections that are made for beds and out patient work loads.

Dr. GRONVALL. May I add to that? I wouldn't want anyone to think that occupancy is not a crucial factor in terms of projecting the future when a medical center is going to be modernized or reconstructed. It gets reflected through the bed sizing model which takes into account the number of veterans being treated and makes a projection based on demographics of future demand for hospital care.

That becomes the basis for the decision about how many beds the medical center needs in the future. Typically, that leads to a projection that the medical center of the future should have fewer beds than now exist as a result of shortening of the length of stay.

So, even though the number of veterans being hospitalized may be projected to increase, significant actual length of stay shortening allows us to project a need for fewer total beds. So, it is in this context that occupancy comes into the bed sizing projections.

Mr. STENHOLM. Mr. Chairman, that is an encouraging statement to me. Having witnessed over the last ten or so years in my rural district in the area of general hospital care considerable Federal funds, State funds, and foundation funds having been spent in various hospital construction programs, somebody missed it.

I don't think it was an error in judgment, but in some instances, we have over-built. In other instances, we have under-built, and I am not sure there is an exact science out there to avoid those kinds of situations. I wouldn't call them mistakes. I don't believe they were mistakes. I believe it is just changing times and changing needs.

That is the general area that I was trying to question you about, and I will be just as interested in the overall rating system when you furnish that for the committee as Mr. Bryant was.

Dr. GRONVALL. Mr. Stenholm, if I may, this is a personal professional observation. Prior to coming to the Veterans' Administration in 1983, I had spent my whole career in university medical centers. So, most of my prior experience has been in the private sector in that context.

During the time I have been in the VA I have stayed very actively involved with the American Hospital Association. I have had the opportunity to be on the board of trustees of the AHA, so I regularly get enmeshed in the kind of considerations you are describing that apply in the private sector as well as in the VA.

My judgment is that the VA, in fact, has done a much better job over the years in really attempting to base its projections for future hospital bed needs on solid information, taking into account demographic projections as well as projections or how medicine is going to be delivered and changed. That is, obviously, a judgment call, but I have worked in both systems.

As a result, I believe the extent of over-bedding that exists throughout the country has not been characteristic of the VA. One of the things that has happened is that as a result of shorter lengths of stay experienced in recent years combined with more beds having been originally built into the medical center than we now need to operate, we have very constructively been able to convert that space either into support space, laboratory space, or, in some cases, nursing home beds.

The tight scrutiny that all of our projects go through with OMB and through the Congress when they are being built originally means that there is very little fat in them. So, over time as the need for beds goes down, usually the projects at the outset were very short of support space, and it has worked to our advantage that we can then convert what used to be bed space no longer needed for beds into the support space that always is short in hospitals.

In summary, as I say, I believe that the match between the size of our facilities and the actual number of veterans being treated in them and the amount of support space that is needed has been better in the VA. That has been a better fit than is characteristic of the private sector.

Therefore, we have not found ourselves in an over-bedding crisis. That term has been used in the private sector in many parts of the country.

Mr. STENHOLM. Thank you.

Thank you, Mr. Chairman.

Mr. MONTGOMERY. Thank you very much, Mr. Stenholm.

We will go back to Mr. Bilirakis and Chris Smith, but before that, let me just ask one question.

What is the VA's current plan for providing hospital care for the Hawaiian veterans? We have been talking about this for ten years now. I hope before I leave Congress we can work it out that we have some type of proper facility for the veteran in Hawaii.

We are getting one story out in Hawaii, and we are getting a bit of a different story, we think, from your office, Dr. Gronvall.

Dr. GRONVALL. I am sorry that there is confusion, Mr. Chairman, so I therefore appreciate your asking the question, and I can try to give you a summary.

We have had a major study in Hawaii during the past year by a team that visited. That team recommended a series of short-term, intermediate-term, and long-term activities to improve the care of veterans in Hawaii.

Within the Department of Medicine and Surgery, we endorsed the short-term and intermediate-term activities, and implementation of those is now underway. We are putting some additional staff in Hawaii, strengthening our out patient clinic, providing additional readjustment counseling center staff, and we have instituted regular and more extensive visits of health care professionals to the outer islands of Hawaii in addition to our activities on Oahu.

The specific question about the future of hospital care is a complex one. The exact current status is that the Department of Medicine and Surgery has recommended that for the long-term strengthening of our medical care there, the Veterans' Administration should build a hospital which would be a primary care type of hospital, utilizing Tripler Army Medical Center as a back-up through a sharing agreement to provide tertiary and complex care to veterans who need that level of hospitalization in Hawaii.

As you know, we currently do utilize Tripler extensively. We have people engaged in revising and updating our sharing agreement with Tripler to do it under the authority of the new Sharing Act, Public Law 97-174.

Our recommendation for a hospital is under study by the Administrator. General Turnage has asked us to provide some additional information and some additional assessments. It is a major decision, of course, for the future, and he has said he wants to be sure that we have explored all of the possible alternatives and have really taken a complete look at the costs, benefits, pros, and cons of each possible alternative.

However, the Department's current proposal, as I say, that is pending review is that we would construct a hospital, continue an intensive and extensive sharing agreement relationship with Tripler on a permanent basis, but have a Veterans' Administration hospital as a part of that.

Mr. MONTGOMERY. Are you checking with General Major out there, the hospital administrator for the Army?

Dr. GRONVALL. Yes, sir, absolutely. We are working closely with Major General Major and Surgeon General Quin Becker of the Army. As I said, we are renegotiating our sharing agreement.

The working agreement we have had with Tripler in the past was not based on the new sharing authority that was enacted by your interest, and we believe that the new sharing agreement which we will have with them will significantly improve our working relationship.

The VA funds and staff that we will provide will amplify and augment the capability of Tripler itself very directly.

Mr. MONTGOMERY. Dr. Gronvall, you all didn't handle this very well. We go out there, and you tell us you are going to give us an answer in the next couple of weeks, and we don't hear anything. It has just been a total delay on working this situation out.

We sure need to get something one way or the other on that situation.

Dr. GRONVALL. I appreciate the comment, and I think it would be well for us to provide to you an updated status report and perhaps meet with the committee staff to discuss in more detail the specific status of each of the things that I have tried to summarize here.

[Subsequently, the Veterans' Administration furnished the following information:]

The status of varied short-term Hawaii implementation items includes: The implementation plan has been approved and we are in the process of transferring the FTEE and salary funds to the Honolulu Outpatient Clinic to add 4 Pharmacy and 6 Medical Administration FTEE to the Clinic at this time. The Clinic will receive an additional 5.85 FTEE for Mental Health Services at the Clinic in fiscal year 1989 plus 7 FTEE to establish a Day Hospital Program. Additional expansions are planned for fiscal year 1990. In June 1987, the Clinic expanded services to the outer isalnds by arranging for monthly visits to each neighboring island by a psychiatrist and social worker. These individuals assist veterans in linking into either local or VA health networks as their individual needs indicate.

During a March 1988 site visit, substantial progress was made toward the creation of Primary Care Clinics that will have adjacent locations to the new Readjustment Counseling Centers on Maui, Kauai, and at Hilo and the Kona Coast on Hawaii. This team did a detailed review of available rental properties at each location and left specific guidelines in place for site acquisition and all details of preparation to activate the new programs. Documents are being prepared for site acquisition (leases) and the process will be formally activiated as soon as authority is provided from the Office of Facilities. Twelve FTEE are being provided this fiscal year for the four Primary Care Clinics plus 12 FTEE for the Counseling Centers. The Honolulu Outpatient Clinic is now recruiting psychiatrists and nurse practitioners for those sites. We are planning to have these sites operational by August 1988.

The Western Region is continually reviewing inpatient needs of Hawaii veterans to assure that an appropriate mix of inpatient services is available utlizing hospitals currently in operation on the several islands pending a decision on the long-term solution of establishing a VA medical center on Oahu.

The Honolulu VA Outpatient Clinic and Tripler Army Medical Center (TAMC) are proceeding very well in their negotiations toward a revised sharing agreement. It is anticipated that those negotiations will be completed and a document forwarded to the Regional Director for necessary reviews by the end of April 1988. Currently, there are weekly meetings between the Outpatient Clinic and TAMC for final refinement of the agreement.

Mr. Montgomery. Thank you.

I would like to ask Dr. Rowland to take the Chair.

Mr. Bilirakis?

Mr. Bilirakis. Thank you, Mr. Chairman.

First, I would like to ask unanimous consent to be able to put a very brief opening statement into the record.

Mr. Rowland of Georgia [acting chairman]. Without objection, so ordered.

Mr. Bilirakis. Thank you, Mr. Chairman.

[The prepared statement of Representative Bilirakis appears on p. 142.]

Mr. Bilirakis. Dr. Gronvall, Mrs. Livingstone in her remarks made comments that the VA is proud of its construction program, et cetera. Yes, I do think you should be proud of it. I really feel strongly that you have done a good job, considering the constraints that have been placed upon you, and I commend you for all of the good parts of it.

Of course, the constraints are the part that bother me always—the fact that we know that Federal spending overall has been at least double the spending that has gone into the Veterans' Administration. So, why should we have that constraint as far as the Veterans' Administration is concerned when there isn't or hasn't been, at least, the same type of constraint in other areas? Those are areas, I think, that we should be addressing.

You also refer here to the six-year program level reflects a 57.7-percent increase in VA construction dollars over the previous six-year period and has enabled the VA to accomplish many critical projects. Well, I don't know how that 57.7 percent—that is awfully impressive—how that relates to overall VA spending during that six-year period, nor do I know how it relates to overall Federal Government spending during that six-year period.

Is that 57.7 percent comparable to 100 percent overall government spending? Then it is not so impressive if we look at it that way.

However, it is up to us to put more emphasis, I think, on that. We have talked about a ten-year plan, and then we have talked about a five-year plan. I think an awful lot of money goes into these VA plans for further construction and further needs.

I guess maybe a general question that I have at this point is, do we pretty well abide by those plans? I realize that every plan is just merely a plan, and there should be very definitely some flexibility.

Mr. Bryant is not here, but he asked a question regarding a couple of projects that were just put on line, if you will, when, in fact, there is a plan which did not even include those. Well, what happens? What causes something like that to happen?

All of a sudden do we have such an increase in veterans' population and veterans' needs that we did not foresee in all those five-year plans and ten-year plans?

Mrs. LIVINGSTONE. Mr. Bilirakis, I might respond initially, and if anyone would care to make additional comments, he can.

The projects that Mr. Bryant was referring to are projects that were in the planning pipeline. Basically, we have had a number of changes and refinements—

Mr. BILIRAKIS. Priorities have changed.

Mrs. LIVINGSTONE. Priorities—well, there was a prioritization methodology developed which was brand new. There can be, although it is fairly unusual, dramatic changes in the planning horizons. For instance, when the application of the diagnostic related groups was instituted in the VA and, in addition, when the length of stay started declining, obviously, that has a very significant impact on what the construction scope of a project might be, given the projected demographics.

So, there can be changes of that nature.

Essentially, although our planning documents are annually revalidated and updated and analyzed, they move forward in a very consistent, coherent fashion, by and large, other than these types of changes that may occur through major refinements in the planning system.

Mr. BILIRAKIS. Let me ask, I guess, maybe a little bit of a loaded question. How much of an effect do Members of Congress have in terms of changes in these plans and changes in the priorities?

Mrs. LIVINGSTONE. Actually, Mr. Bilirakis, I am pleased to respond to that, because the VA's construction program, I think, is not politicized in that way. The Congress adds to our budget request every year, but they do not ask us to redirect or change the priorities that we have requested in our budget.

So, the VA does put forward its priorities in its request to both the Office of Management and Budget and, subsequently, in the President's budget that is submitted to Congress. Then, Congress, at least for the last several years, has added additional projects to our request. Those projects have not in all instances been in our priority order, but those are, again, Congressional actions that are taken.

Mr. **Bilirakis**. Well, but are additional dollars added in addition to the projects?

Mrs. **Livingstone**. Yes, sir. There have been additional dollars specifically appropriated for the last couple of years for the additional projects beyond the VA's request.

Mr. **Bilirakis**. I would just make one final request and not ask for an answer now but ask that you submit it to me.

The domiciliary—Florida has, strange as it sounds, no domiciliaries and, finally, one is in the works. I want to be sure that that is on line, and I want to be sure that the State of Florida is being timely in terms of its part in all that.

So, I would appreciate it—I don't know whether it is your area or Mrs. Livingstone's—if somebody—I don't want to take up any more time here, but I would appreciate it if you could submit that to me as soon as you can so that we can do whatever is necessary to get them jacked up if, in fact, they are running behind as far as the time table is concerned.

Dr. **Gronvall**. We will certainly do that, Mr. Bilirakis. You used the term "domiciliary." I think it is a Florida State home, a State nursing home that you are inquiring about.

Mr. **Bilirakis**. Right, sure.

Dr. **Gronvall**. And we handle those as a grant program through the Department of Medicine and Surgery. We will give you a status report and keep you informed.

Mr. **Bilirakis**. If you would, sir. I just want to be helpful towards that end.

Dr. **Gronvall**. We would be pleased to.

Mr. **Bilirakis**. Thank you.

Thank you, Mr. Chairman.

[Subsequently, the Veterans' Administration furnished the following information:]

The State of Florida submitted their second set of drawings and specifications for the above project on March 1, 1988. These drawings were sent to the VA architect on March 4, 1988. A meeting with designated Florida staff and the VA architectect took place on March 29, 1988, to discuss drawings and specifications. The next steps include: submission of final drawings and specifications, bid tabulations and revised budget. When the final drawings and bid tabs are approved, an award may be granted. The Florida staff have targeted August 1988 for meeting all requirements so that a grant may be awarded in September 1988.

Dr. **Rowland** of Georgia. Thank you, Mr. Bilirakis, and I want to thank the panel very much this morning. We may have some additional questions to submit. We would appreciate your prompt response to them.

Thank you all very much for being here this morning.

Mrs. **Livingstone**. Thank you, Mr. Chairman.

Dr. **Rowland** of Georgia. We have two additional panels, and I am going to call these two panels at the same time. We are operating under some time constraints.

I want to call Mr. Samuel Walsh, Assistant Director of the National Legislative Commission of the American Legion; Mr. Rodney Kirk, Assistant Director of the National Veterans' Affairs and Rehabilitation Commission; Mr. David Gorman who is with the Disabled American Veterans; Mr. James Magill who is with the Veterans of Foreign Wars; Mr. Frank DeGeorge, Paralyzed Veterans of

America; and Mr. Tom Davies, Associate Director of Architecture and Barrier Free Design for the Paralyzed Veterans of America.

If all of you would come to the table, we would appreciate it.

I would ask you, gentlemen, to summarize your statements this morning. Your entire statement will be made a part of the record.

We do appreciate very much all of you being here.

We will ask Mr. Walsh to proceed at this time.

STATEMENT OF SAMUEL J. WALSH, ASSISTANT DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, THE AMERICAN LEGION; ACCOMPANIED BY: RODNEY S. KIRK, ASSISTANT DIRECTOR, NATIONAL VETERANS' AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

Mr. Walsh. Good morning, Mr. Chairman and members of the subcommittee.

We are pleased to be here to testify on behalf of the American Legion this morning. With me this morning is Mr. Kirk who will read the brief statement.

Mr. Kirk. Thank you, Mr. Walsh.

Again, I repeat what Mr. Walsh just said. The American Legion is pleased to appear here this morning to present our views on the present status as well as the future of the Veterans' Administration's construction budget.

The fiscal year 1989 budget requests $367.8 million for major projects, $123.8 million for minor projects, and $9 million for the parking garage revolving fund. This represents a bottom line decrease in VA's total construction budget of $22 million from the previous year's level down to $500.6 million.

At first glance, the $367.8 million for major projects might appear to indicate a substantial concentration within VA in terms of replacement and modernization efforts. However, it is clearly evident that several areas of funding under major construction, although extremely important and urgently needed, do not relate to medical facility construction in the true sense.

As this subcommittee well knows, almost 25 percent of the $367.8 million appropriated for the major construction projects will be absorbed through asbestos abatement, hazardous waste abatement, Calverton National Cemetery, Washington State sales tax, and Bronx contractor claims.

The American Legion was certainly pleased to see that the Veterans' Affairs Committee recommended to the Budget Committee the addition of $15 million to the budget for design funds for the clinical addition and spinal cord injury unit at Dallas VAMC. The extreme need for these very same projects was expressed in the report issued following the site visit by an American Legion field representative to the Dallas facility one year ago this March.

Likewise, we were pleased to see that the Veterans' Affairs Committee also recommended to the Budget Committee additional funds to construct urgently needed nursing home care units at VAMC's Mountain Home; Wilkes-Barre; and Gainesville, Florida. We strongly encourage and recommend and support this committee's recommendations.

The fact is that many of the VA medical center's systems physical plants have been allowed to deteriorate. The end result is that the system today has some of the finest and most modern up to date facilities in the country and, at the same time, is using extremely outdated facilities. These outdated facilities, over 50 percent of which are 30 years old or older, have serious functional and space deficiencies, fire and safety concerns, patient privacy shortcomings, inadequate mechanical and electrical systems, life safety code violations, and many other discrepancies and inadequacies which much be immediately addressed.

The American Legion certainly understands that all VA medical centers cannot, are not, and will not be newly constructed buildings. For the most part, the majority of the proposed construction budget funds this year, as in the past, will be utilized to renovate and upgrade extremely old and out-dated facilities, bringing them up to modern standards.

The American Legion does feel very strongly, however, that VA medical centers should have ample space and be provided with necessary modern equipment. We expect the existence of hospital environments that do not jeopardize the safety and well-being of veteran patients and staff and environments that are conducive to practicing modern-day medicine. Anything less will not be acceptable to the American Legion.

In conclusion, Mr. Chairman, the American Legion believes very strongly that it is important to maintain the capital plant of the VA medical system and that adequate funds must be provided to upgrade and replace the existing facilities. The American Legion will continue to closely monitor on-going renovation and replacement projects and other construction, both major and minor, throughout the system through reports by our department service officers and surveys by our field representatives.

As is our present practice, we will continue to provide copies of our site visit reports to this committee which contain information on the progress of on-going construction as well as the construction needs that are identified at specific VA medical centers.

Mr. Chairman, we thank this subcommittee again for the opportunity and will be happy to respond to questions at the conclusion of testimony.

[The prepared statement of the American Legion appears on p. 143.]

Dr. ROWLAND of Georgia. Thank you very much.

Mr. Gorman?

STATEMENT OF DAVID W. GORMAN, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR FOR MEDICAL AFFAIRS, DISABLED AMERICAN VETERANS

Mr. GORMAN. Thank you, Mr. Chairman.

Mr. Chairman, I think our initial review of the Administration's fiscal year 1989 budget request in order to support the VA's medical construction program again makes it clear that it appears inadequate to meet the current needs of the system as well as the future demands that will be placed on the health care system within the next few years.

We have offered our view to the subcommittee on a number of previous occasions, Mr. Chairman, that the ability of the VA to provide quality health care services to veterans depends in large part on the prescence of modern, safe, and efficient medical care facilities. This budget request, in our view, continues down the path that has been traveled in past years of insufficient funds to accomplish the reasonable expansion, renovation, modernization, and replacement of the VA's existing medical facilities.

As you know, Mr. Chairman, the VA is requesting $500.6 million to fund its various construction programs in fiscal year 1989 which is $22.1 million less than fiscal year 1988 levels. Of this total, $413 million will be devoted to the medical care system.

Of continuing concern to the DAV is the VA's policy of relying more and more on non-VA owned and operated nursing home care beds to attempt to meet the long-term care needs of disabled veterans. Of the current budget request, only $9.7 million or less than 2 percent of the requested program level is to be devoted to nursing home care bed conversion, renovation, and construction.

Mr. Chairman, this situation becomes even more disturbing when we note that the VA is proposing to convert only a meager number of acute care beds to long-term care beds. Clearly, the agency's ability to accomplish bed conversions can only be described as dismal based on their past efforts.

Also, funds for only one 120-bed nursing home care unit, is projected in this budget request, which leads us to seriously question the commitment of the agency to accommodate the demand for long-term care services to disabled veterans.

At this point, Mr. Chairman, I would offer the DAV's genuine appreciation for the action recently taken by the full committee in its report to the Budget Committee of the House proposing funds for the construction of 120-bed nursing home care units at Mountain Home, Tennessee and Gainesville, Florida together with a 60-Bed unit at Wilkes-Barre, Pennsylvania as well as the funding of $15 million for a clinical addition and spinal cord injury unit at the VA medical center in Dallas, Texas.

Mr. Chairman, we continue to support the concepts embodied by the advance planning fund and the design fund as included in the Administration's budget.

Finally, Mr. Chairman, I would mention the construction portion as well as appendix B of the independent budget for veterans which has been provided to the members of the subcommittee, and we would urge the careful consideration of the concepts and outline therein. I think the major studies that have examined the VA's construction process have clearly identified multiple and serious flaws and problems, some of which continue to exist today, in the construction process.

Until remedies are in place, addressing issues such as the excessive time required to complete projects, the end users' dissatisfaction with the completed projects, the prioritization process of the construction projects, and a system-wide objective review of the program, the VA's medical construction program will, in our opinion, continue to fall short of its potential in meeting the needs of disabled veterans now and in the future.

That concludes my testimony, Mr. Chairman. I would like to thank you for the chance to be here this morning.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Gorman appears on p. 148.]

Dr. ROWLAND of Georgia. Thank you, Mr. Gorman.

Mr. Magill?

STATEMENT OF JAMES MAGILL, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS

Mr. MAGILL. Thank you, sir.

As you know, the Veterans of Foreign Wars was proud to have been a part of the independent budget that was presented to this committee a couple weeks ago. Unlike the previous year, we took on the whole budget. Of course, part of that was the medical construction program.

I would like to once again add that this budget that we presented is, as the name implies, an independent budget, and that, of course, means it is independent of the influence of the Office of Management and Budget. We believe also that the figures that we presented to you at that time for the construction program are basically the minimum figures that need to be funded in order that veterans may be served.

As in other VA programs, the basis for determining the appropriate levels of funding for construction is based on need. However, the VFW believes the VA does not have the information required to formulate needs based construction budgets.

In formulating a budget, an inventory basis should include the recognition of maintenance and repair needs of existing structures and systems. Currently, the VA's construction priority setting is limited to choosing among projects submitted by medical centers in the five-year facility plan.

These projects may or may not address the needs of the VA on the whole, as the VA sees them on a priority basis. The current prioritization method simply, in our opinion, places requested projects in a priority order and does not address true priority need.

In addressing the VA's construction needs, our most urgent concern is for the VA to develop a construction process that works well. We envision a process that completes projects more rapidly, chooses projects based on need and on a sound system for setting priorities, provides projects that adequately meed medical centers' needs, is economical, and catches problems quickly before they become severe.

With respect to funding levels, we believe a minimum of $368 million would be appropriate for the major construction and $35 million less than fiscal year 1988. We say that because, as we stated in the budget, the VA, we don't believe, has basically the information it needs to make sound choices.

However, we do believe that minor construction should be increased. A lot of these medical centers, as was mentioned before, are quite old, and they need to be redesigned, if possible. A lot of them are made out of poured concrete which I think probably requires a jack hammer in order to come in and fix them.

That concludes my statement because of the time constraint. You do have my full statement, and, once again, I would ask you to look at the independent budget with respect to the construction programs.

Thank you, sir.

[The prepared statement of Mr. Magill appears on p. 154.]

Dr. ROWLAND of Georgia. The independent budget was used a great deal in formulating our budget, and we appreciate that.

Mr. MAGILL. We recognize that, sir. Thank you very much.

Dr. ROWLAND of Georgia. Thank you, Mr. Magill.

Mr. DeGeorge?

STATEMENT OF FRANK DE GEORGE, ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; ACCOMPANIED BY: TOM DAVIES, ASSOCIATE DIRECTOR OF ARCHITECTURE AND BARRIER FREE DESIGN, PARALYZED VETERANS OF AMERICA

Mr. DEGEORGE. Thank you, Mr. Chairman.

In addition to our testimony, we ask that the committee members refer to the construction portion of the independent budget which, with your permission, is submitted for the written record.

Dr. ROWLAND of Georgia. Without objection, so ordered.

[See p. 160.]

Mr. DEGEORGE. Thank you, Mr. Chairman.

Mr. Chairman, as in years past, in the absence of a comprehensive system for assessing total VA medical facility needs, it is difficult to comment on the adequacy of any construction budget request since there is no mechanism for quantifying total facility deficiencies. The VA does not have the information required to formulate a needs based construction budget.

This is, indeed, an unfortunate and shameful situation that underscores the urgent need for the timely and proper implementation of the core process recommendations identified in the Booz Allen Hamilton/RTKL comprehensive study of the VA construction process which was completed in 1985. Properly implemented, these much-needed procedural changes will allow decision makers to measure the impact of the construction budget on the total VA facility need.

At the present time, there is no inventory of construction needs, and the focus of the recently completed capital facility study is far too narrow to fulfill this role.

A clear understanding of the Booz Allen core process recommendations should have been a prerequisite to organizational realignment followed by preparation of a realistic and detailed implementation plan with the schedules, milestones, and priorities. However, the Office of Facilities has concentrated their efforts to date on the facility development plan program rather than simultaneously moving ahead with other core process recommendations.

A facility planning data base can, in fact, be developed simultaneously with the FDP program. The data base described in the Booz Allen study which could assist your committee in determining overall VA facility deficiencies is not dependent on the completion of 172 FDP's. In fact, gathering this data independently will both expedite the FDP process and reduce associated costs.

One core process recommendation which warrants immediate attention is that which addresses VA design standards and criteria, information which affects the planning data base and every proposed VA construction project. The Booz Allen and Hamilton study was the second report in the past decade to cite major deficiencies in the design standards and criteria. An earlier report prepared by Shotwell-Anderson—October, 1978—identified similar problems and also contained specific guidelines and detailed recommendations which were never adopted.

Maintenance of accurate criteria is fundamental in operating a national system of health care services, providing a basis for uniform levels of service, and establishing a formal mechanism for "corporate memory," learning from experience to prevent future mistakes.

In 1985, Booz Allen and Hamilton, much like Shotwell-Anderson in 1978, identified the VA design criteria as, one, based on unreliable information which is not conveniently available; two, obsolete in some areas; three, based on incorrect assumptions regarding operating modalities; and, four, inflexible. In 1988, PVA feels that the Office of Facilities has made little progress, with the exception of a spinal cord injury design guide, in this critical task.

A second concern is the lack of construction resources for much-needed facilities for our aging veterans in light of the increasing demand for extended care services. We acknowledge the need to examine alternatives for nursing home care, but attempts to shift the burden of care to public and contracted private health care providers should be carefully considered since these sectors may well be equally ill-equipped, unable, or unwilling to accept this demand.

The recent study commissioned by PVA entitled, "Veterans' Health Care: Actions and Interactions," clearly indicates that reducing or eliminating current services will only result in a cost transfer, shifting the financial burden to other public and private health providers with no real net savings.

The Administration budget for VA construction which reduces funding for construction by $22.1 million for fiscal year 1989 is clearly inadequate. However, PVA commends the House Veterans' Affairs Committee for its actions in restoring funding during their markup of March 10, 1988 and, specifically, for restoration of design funds for the clinical addition and spinal cord injury project at the VA medical center in Dallas, Texas.

Sir, with your permission, I have just one more moment.

Dr. **Rowland** of Georgia. Without objection.

Mr. **DeGeorge**. PVA also appreciates your support for $8 million budgeted for a 30-bed spinal cord injury center at San Antonio, Texas. Additionally, the committee's efforts to provide more adequately for long-term care facilities is also noteworthy.

In conclusion, without reliable statistical information on the VA medical facilities, we feel that there is no logical basis for resource allocation, nor are we confident that the facilities being constructed provide the best possible care for veterans at the most reasonable cost to the taxpayer. To provide Congress with reliable information upon which to fund the VA construction program, the Office of Facilities must move rapidly to implement the Booz Allen and Hamilton study recommendations. Without proper oversight, we fear that the basic objectives of the BAH study and the VA study, "Caring for the Older Veteran," will be lost, and their implementation will be delayed indefinitely.

This concludes our testimony. Again, thank you, Mr. Chairman, and we will also be pleased to respond to any questions that you may have.

[The prepared statement of Mr. DeGeorge appears on p. 157.]

Dr. ROWLAND of Georgia. May I express my sincere appreciation to all of you here this morning. Also, on behalf of the committee, I thank you for what you do in supporting us and helping us arrive at the proper decisions.

Let me urge you also to talk with the members of the Appropriations Committees, because that is where a lot of the action is going to be. So, if there is any way we can be of assistance to you in that respect, please let us know.

Thank you again so very much for being here this morning. I don't have any questions.

We will ask that the record remain open for five working days so that members of the committee may submit statements if they so desire.

Thank you very much.

The subcommittee stands adjourned.

[Whereupon, at 10:59 a.m., the subcommittee adjourned, to reconvene subject to the call of the Chair.]

APPENDIX

Statement of the
Honorable G.V (Sonny) Montgomery
Chairman, Subcommittee on Hospitals
and Health Care
Committee on Veterans' Affairs

Good Morning. The purpose of the hearing this morning is to receive testimony about the VA's medical construction program.

It is important to remember the fundamental nature of the construction program: it makes possible the delivery of quality health care to veterans; it provides the facilities in which a significant amount of our Country's medical education and research take place; and it ensures a valuable national contingency resource for defense and other emergency situations. It also provides an unmistakable symbol of our collective gratitude for veterans' sacrifices.

When we talk today about the cost of medical construction, whether major clinical additions or minor maintenance, we must remember the importance of the program. It would certainly have been helpful in preparing for this hearing if the VA's Capital Facility Plan had been provided to us.

Our discussions about needed construction must take place within a context of the current condition of VA medical facilities and the goals of the Department of Medicine and Surgery. Therefore, the DM&S Strategic Planning Projections for fiscal years 1988-1992 has been informative. However, somewhat less useful is the Five Year Medical Facility Development Plan which, for example, includes no projections for VA nursing homes.

As we discussed during the full Committee's budget hearing and markup, the Administration's budget for fiscal year 1989 requested a 4.3 percent decrease, or $22.1 million, from the fiscal year 1988 construction level. The total request for construction was $500 million. This included an 8.8 percent decrease in major construction funding. This seemed inadequate to the Committee. Over half of the VA's medical facilities are over 30 years old. The practice of medicine has changed dramatically and the needs of veteran patients have changed as they have grown older.

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Therefore, the Committee recommended an increase of $15 million for design funds for the clinical addition and spinal cord injury center for the Dallas VA Medical Center and $16.4 million for three nursing homes in Mountain Home, Tennessee; Wilkes-Barre, Pennsylvania; and Gainesville, Florida. This is a very modest increase of $31.4 million. Certainly there are many more justified uses to which construction funds may be put and it is in recognition of the budget deficit that we have recommended this amount.

My colleagues, Jim Traficant of Ohio, Sonny Callahan from the State of Alabama and Patrick Swindall from Georgia have submitted testimony for inclusion in the hearing record. Without objection, it is so ordered.

I want to welcome our witnesses and again express the sincere appreciation of the subcommittee for their time and interest in VA medical care.

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TESTIMONY OF
REPRESENTATIVE JAMES A. TRAFICANT, JR.
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
334 CANNON HOUSE OFFICE BUILDING
MARCH 16,1988

I would first like to thank Chairman Sonny Montgomery and the other Members of the Subcommittee for extending me the invitation to appear before you today on the subject of the Fiscal Year 1989 Veterans' Administration medical facilities construction proposal. Although I am not able to appear before you in person, I did want to submit testimony for the record.

The purpose of my testimony is to bring to your attention a critical facilities shortfall involving the VA Medical Center in Pittsburgh, PA.

The Pittsburgh Medical Center is scheduled to be allocated $5 million in Fiscal Year 1993 for the construction of a 750 car garage. However, a large majority of the veterans in my congressional district and that my colleague, Representative Applegate, who need medical care currently utilize the Pittsburgh medical facility. A severe parking shortage exists now at the VA facility and needs to be addressed before 1993.

It is my understanding that as a result of the current parking situation at the Pittsburgh VA facility, veterans in the northeastern Ohio region must leave in the middle of night in order to get a parking space. Under normal conditions, this trip usually takes approximately one hour. As I am sure you would all agree, this is an unfortunate situation and one in which veterans should not have to subject themselves to in order to receive medical attention.

I would respectfully request that Chairman Montgomery and the other distinguished Members of the Hospitals and Health Care Subcommittee carefully consider advancing the timetable for funding this project. According to the Medical Center Director in Pittsburgh, a number of alternatives have been explored, but only one, the construction of a new 750 car garage will solve the current parking crisis.

Again, I want to thank the Chairman and other Members of the Subcommittee for allowing me the opportunity to submit this testimony and look forward to working with you on this project in the coming months.

STATEMENT OF CONGRESSMAN SONNY CALLAHAN SUBMITTED TO THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE HOUSE COMMITTEE ON VETERANS' AFFAIRS

MARCH 16, 1988

MR. CHAIRMAN, I DEEPLY APPRECIATE THIS OPPORTUNITY TO SUBMIT IN THE RECORD OF THIS HEARING MY VIEWS ON THE IMPORTANCE OF THE FISCAL YEAR 1989 BUDGET FOR CONSTRUCTION OF MEDICAL FACILITIES FOR THE VETERANS ADMINISTRATION.

AS THE U.S. REPRESENTATIVE FOR THE FIRST CONGRESSIONAL DISTRICT OF ALABAMA AND A NAVY VETERAN, I AM KEENLY AWARE OF THE NEED FOR ADEQUATE HEALTH CARE FACILITIES AND SERVICES FOR OUR NATION'S VETERANS. FOR THE 60,940 VETERANS OF MY CONGRESSIONAL DISTRICT, THE CLOSEST AVAILABLE MEDICAL CARE IS A V.A. OUTPATIENT CLINIC IN MOBILE. IT CONSISTS OF APPROXIMATELY 2000 SQUARE FEET AND EXPERIENCES ABOUT 7,000 TO 9,000 VISITS EACH YEAR.

UNFORTUNATELY, THIS FACILITY IS INADEQUATE FOR MEETING THE HEALTH CARE NEEDS OF THE VETERANS IN MY CONGRESSIONAL DISTRICT OF SOUTHWEST ALABAMA. MY OFFICE CONTINUALLY RECEIVES COMPLAINTS ABOUT THE PHYSICAL CONDITION OF THE MOBILE CLINIC, WHICH LACKS A PATIENT WAITING ROOM, PHARMACY, AND X-RAY FACILITIES. THE MOBILE CLINIC IS ALSO WITHOUT LABORATORY FACILITIES, THUS REQUIRING NECESSARY LAB WORK TO BE SHUTTLED BY BUS TO AND FROM THE V.A. FACILITY IN PENSACOLA, FLORIDA.

IF ANY COMMUNITY NEEDS AN IMPROVED FACILITY, I BELIEVE IT

IS MOBILE. OUR POPULATION IS AGING, AS ARE OTHER COMMUNITIES', YET MOBILE IS WITHOUT A PUBLIC HOSPITAL TO SERVE THESE INDIVIDUALS. THE CLOSEST INPATIENT SERVICES FOR MY CONSTITUENTS ARE AT THE V.A. HOSPITAL IN BILOXI, MISSISSIPI.

WITH LIMITED FEDERAL DOLLARS, IT IS REGRETTABLE THAT MANY OF OUR VETERANS EXPERIENCE SUCH DIFFICULTIES IN RECEIVING THE MEDICAL CARE THEY NEED. THE CLINIC IN MOBILE ALSO HAS A SERIOUS PERSONNEL SHORTAGE. ALTHOUGH PATIENT VOLUME HAS BEEN INCREASING, THE CLINIC REMAINS STAFFED WITH TWO DOCTORS AND TWO NURSES -- THE SAME STAFFING IT HAD WHEN IT FIRST OPENED IN 1974. HOWEVER, THERE SEEMS TO BE A CONSENSUS IN THE COMMUNITY THAT THE MOBILE CLINIC STAFF IS DOING ALL THAT IS HUMANLY POSSIBLE FOR OUR AREA VETERANS, EVEN WITH SUCH TRYING CONDITIONS.

AS I CONCLUDE MY REMARKS, I WOULD BE REMISS IF I DID NOT EXPRESS MY APPRECIATION FOR CHAIRMAN MONTGOMERY'S SUPPORT OF OUR EFFORTS TO IMPROVE THE MOBILE V.A. OUTPATIENT CLINIC. HIS CONCERN AND DILIGENCE TOWARD THE ACHIEVEMENT OF THIS GOAL CANNOT BE OVERSTATED. I KNOW THE VETERANS OF MY CONGRESSIONAL DISTRICT AND THE NATION FEEL FORTUNATE TO HAVE SUCH A CARING AND INFLUENTIAL INDIVIDUAL WORKING ON THEIR BEHALF.

AGAIN, MR. CHAIRMAN, THANK YOU FOR ALLOWING ME TO PRESENT MY VIEWS.

COMMITTEE ON BANKING, FINANCE AND URBAN AFFAIRS

SUBCOMMITTEES:

FINANCIAL INSTITUTIONS SUPERVISION, REGULATION AND INSURANCE

INTERNATIONAL FINANCE, TRADE AND MONETARY POLICY

INTERNATIONAL DEVELOPMENT INSTITUTIONS AND FINANCE

HOUSING AND COMMUNITY DEVELOPMENT

ECONOMIC STABILIZATION

Congress of the United States

PATRICK L. SWINDALL

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COMMITTEE ON THE JUDICIARY

SUBCOMMITTEES

IMMIGRATION, REFUGEES AND INTERNATIONAL LAW

ADMINISTRATIVE LAW AND GOVERNMENT RELATIONS

CRIMINAL JUSTICE

SELECT COMMITTEE ON AGING

SUBCOMMITTEE

RETIREMENT INCOME AND EMPLOYMENT

March 15, 1988

The Honorable G. V. Montgomery
Chairman
Subcommittee on Hospitals
& Health Care
338 Cannon H.O.B.
Washington, D.C. 20515

Dear Mr. Chairman:

I am writing to encourage the Subcommittee to include the $54.2 million for the Clinical Addition and Modernization project at the Veterans Administration Medical Center in Atlanta, Georgia in its recommendations for the Construction Resolution for FY 1989.

There is a great need for the proposed improvements to the Medical Center because of the importance of this facility to the veterans in Atanta and the entire state of Georgia. The clinical addition will alleviate the space problems that serverely hamper patient care. This Medical Center has the smallest number of beds of any major metropolitan area and is 47 percent below VA space requirements for the various clinical services provided there. The limited facilities prevent adequate service for the 400,000 veterans who live in Georgia. In addition, the number of veterans over 65 years of age served by this Medical Center is expected to rise by an extraordinary 133% by the year 2000.

I wholeheartedly support this important expansion project and respectfully urge you to accept the recommendations of the national VA and approve the funding.

With best regards, I am

Sincerely,

PAT SWINDALL
Member of Congress

PLS/jof

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DEKALB OFFICE
160 CLAIRMONT AVENUE
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CONYERS, GA 30207
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COVINGTON, GA 30209
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STATEMENT OF HON. GERALD B.H. SOLOMON

THANK YOU MR. CHAIRMAN.

THE FULL COMMITTEE HAS ALREADY SUBMITTED ITS REPORT TO THE BUDGET COMMITTEE WITH RESPECT TO VA'S BUDGET FOR FISCAL YEAR 1989. INCLUDED IN THAT REPORT WERE OUR RECOMMENDATINOS ON VA CONSTRUCTION. IN MY VIEW, OUR ADD-ON'S WERE NECESSARY AND YET MODEST. WE ASKED FOR $31.4 MILLION DOLLARS TO BE ADDED TO VA'S REQUEST OF SOME $500 MILLION. THESE ADDITIONAL FUNDS WOULD BE FOR THE NURSING HOMES YOU HAVE MENTIONED AND FOR THE CLINICAL ADDITION AND SPINAL CORD INJURY CENTER AT DALLAS. THESE PROJECTS ARE VITALLY NEEDED AND HAVE BEEN FULLY JUSTIFIED.

INDEED THE NURSING BEDS TO BE ADDED TO THOSE ALREADY IN EXISTENCE ARE A MINIMUM NUMBER IN TERMS OF CURRENT AND FUTURE NEEDS.

MR. CHAIRMAN, I NOTE THAT MRS. SUSAN LIVINGSTON WILL TESTIFY ON BEHALF OF THE VA. I TRUST THAT IN ADDITION TO HER COMMENT ON THE SPECIFICS OF THE CONSTRUCTION BUDGET SHE WILL ALSO UPDATE US ON SEVERAL ONGOING PROJECTS AND INITIATIVES DESIGNED TO IMPROVE THE VA CONSTRUCTION PLANNING AND EXECUTION IN THE CONSTRUCTION FIELD.

THANK YOU, MR. CHAIRMAN.

STATEMENT
BY
SUSAN LIVINGSTONE
ASSOCIATE DEPUTY ADMINISTRATOR FOR LOGISTICS
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
OF THE
COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES
ON
MARCH 16, 1988

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE, I AM PLEASED TO APPEAR BEFORE YOU THIS MORNING TO PRESENT TESTIMONY CONCERNING THE VETERANS ADMINISTRATION'S CONSTRUCTION REQUEST CONTAINED IN THE PRESIDENT'S BUDGET FOR FY 1989.

THE FY 1989 BUDGET REQUESTS A CONSTRUCTION PROGRAM LEVEL OF $500,636,000 IN SUPPORT OF PROJECTS FOR THE DEPARTMENT OF MEDICINE AND SURGERY (DM&S), THE DEPARTMENT OF VETERANS BENEFITS (DVB) AND THE DEPARTMENT OF MEMORIAL AFFAIRS (DMA). THIS AMOUNT INCLUDES AN APPROPRIATION REQUEST FOR MAJOR PROJECTS OF $367,755,000, A MINOR PROGRAM REQUEST OF $123,881,000 AND A PARKING GARAGE REVOLVING FUND REQUEST OF $9,000,000. OF THE $500,636,000 REQUESTED, $421,840,000 IS FOR MEDICAL FACILITIES PROJECTS INCLUDING THE PARKING GARAGE REVOLVING FUND; $10,665,000 IS FOR DVB REGIONAL OFFICE PROJECTS; $17,900,000 IS FOR THE NATIONAL CEMETERY PROGRAM; $7,500,000 IS FOR STAFF OFFICES; AND $42,731,000 IS FOR GENERAL ADMINISTRATION.

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THE VETERANS ADMINISTRATION'S FY 1989 CONSTRUCTION BUDGET INCLUDES FUNDING FOR CONSTRUCTION OF MAJOR REPLACEMENT/MODERNIZATION PROJECTS IN ATLANTA, GEORGIA, AND PITTSBURGH (ASPINWALL DIVISION), PENNSYLVANIA.

WE ALSO ARE REQUESTING FUNDING IN FY 1989 FOR DESIGN OF CLINICAL IMPROVEMENTS AND A MENTAL HEALTH AND BEHAVIORAL SCIENCES CENTER IN INDIANAPOLIS, INDIANA, AND FOR DESIGN OF A COMPREHENSIVE MODERNIZATION PROJECT IN NEWINGTON, CONNECTICUT.

IN ADDITION, THIS BUDGET REQUEST INCLUDES THREE CLINICAL IMPROVEMENT PROJECTS AT VA MEDICAL CENTERS IN BECKLEY, WEST VIRGINIA; NASHVILLE, TENNESSEE; AND PERRY POINT, MARYLAND; A 30-BED SPINAL CORD INJURY CENTER PROJECT IN SAN ANTONIO, TEXAS; A FIRE AND SAFETY/PATIENT PRIVACY IMPROVEMENT PROJECT IN LEAVENWORTH, KANSAS; A 600-BED DOMICILIARY PROJECT IN MOUNTAIN HOME, TENNESSEE; RENOVATION OF A PATIENT CARE BUILDING IN MONTROSE, NEW YORK; DEVELOPMENT OF 90,000 NEW GRAVESITES AT THE CALVERTON, NEW YORK, NATIONAL CEMETERY; AND THE COLOCATION OF THE MONTGOMERY, ALABAMA, DVB REGIONAL OFFICE ONTO VA-OWNED GROUNDS WITH THE MEDICAL CENTER. THE BUDGET REQUEST FURTHER PROVIDES FUNDS FOR CONSTRUCTION OF 360 NURSING HOME CARE BEDS WITH A NEW 120-BED NURSING HOME CARE UNIT IN TAMPA, FLORIDA, AND A NEW 240-BED NURSING HOME CARE UNIT REPLACING THE EXISTING OUTDATED 228 NURSING HOME CARE BEDS AS PART OF THE PITTSBURGH (ASPINWALL DIVISION) PROJECT. IN ADDITION, THE BUDGET REQUESTS ADVANCE PLANNING MONIES AND DESIGN FUNDS FOR DEVELOPMENT AND DESIGN OF FUTURE YEAR PROJECTS FOR DM&S, DVB AND DMA.

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FINALLY, WE WOULD HIGHLIGHT THAT OUR FY 1989 BUDGET INCLUDES $10 MILLION FOR THE NATIONWIDE INITIATIVE WE HAVE TO PROVIDE FACILITY DEVELOPMENT PLANS FOR ALL OF OUR VA MEDICAL CENTERS. FACILITY DEVELOPMENT PLANS (OR FDP'S) WILL PROVIDE A COMPREHENSIVE, NATIONWIDE ASSESSMENT OF VA MEDICAL CENTER FACILITY NEEDS TO THE YEAR 2000 AND BEYOND. AN FDP WILL BE DONE FOR EACH VA MEDICAL CENTER AND WILL PROVIDE AN ASSESSMENT OF ALL THE MEDICAL, FUNCTIONAL AND PHYSICAL PLANT NEEDS OF THE INDIVIDUAL MEDICAL CENTER AS PROJECTED BY OUR MEDICAL PLANNING SYSTEM. EACH FDP ALSO WILL PROVIDE A PLAN FOR THE EXPANSION, RENOVATION AND REPLACEMENT NEEDED TO FULFILL THE MISSION OF EVERY ONE OF OUR MEDICAL CENTERS.

THESE PLANS, WHICH WILL BE ANNUALLY REVALIDATED AND UPDATED, WILL HELP US TO GREATLY REFINE OUR FACILITY PLANNING, ASSIST US IN PRIORITIZING CONSTRUCTION PROJECTS AND HELP US IN SCHEDULING AND ALLOCATING CONSTRUCTION BUDGET RESOURCES. INDEED, THESE FDP'S WILL PROVIDE THE VA FOR THE FIRST TIME WITH INTEGRATED, SYSTEMWIDE, DOCUMENTED PLANS TO MEET THE FACILITY REQUIREMENTS OF DM&S IN THE YEARS TO COME BASED ON THE DEPARTMENT'S NEEDS AS IDENTIFIED THROUGH MEDIPP AND OTHER VA MEDICAL PROGRAM PLANNING DATA.

THE VA HAS A TREMENDOUS CAPITAL INVESTMENT RESPRESENTED BY OUR OVER 5000 BUILDINGS AND OVER 26,000 ACRES OF LAND. IT IS CRITICAL TO OUR MISSION THAT THE VA PRESERVE, MAINTAIN AND ENHANCE THIS PHYSICAL PLANT TO INSURE ITS CAPABILITY TO DELIVER STATE OF THE ART MEDICAL CARE AND RESPOND TO THE CHANGING NEEDS OF THIS NATION'S VETERANS. OUR FY 1989 BUDGET REQUEST CONTINUES OUR COMMITMENT TO A CAPITAL INVESTMENT PROGRAM WHICH RESPONDS TO THESE GOALS.

THE VA IS PROUD OF ITS CONSTRUCTION PROGRAM AND BELIEVES OUR FY 1989 REQUEST, REPRESENTS A REASONABLE REQUEST IN THE CURRENT ENVIRONMENT OF CONSTRAINED BUDGET RESOURCES. FOR THE SIX-YEAR PERIOD (FY 1983-FY 1988), THE VA'S CONSTRUCTION PROGRAM RECEIVED $4.3 BILLION IN FUNDING TO BUILD NEW MEDICAL, CEMETERY AND VA REGIONAL OFFICE FACILITIES. THIS SIX-YEAR PROGRAM LEVEL REFLECTS A 57.7 PERCENT INCREASE IN VA CONSTRUCTION DOLLARS OVER THE PREVIOUS SIX YEAR PERIOD (FY 1977-FY 1982) AND HAS ENABLED THE VA TO ACCOMPLISH MANY CRITICAL PROJECTS. GIVEN THIS FUNDING LEVEL, WE ARE PLEASED TO REPORT THAT IN FY 1987, THE VA OBLIGATED OVER $766 MILLION IN CONSTRUCTION APPROPRIATIONS, THE LARGEST SINGLE-YEAR CONSTRUCTION PROGRAM IN VA HISTORY. MAJOR AWARDS INCLUDED $175.4 MILLION FOR CONSTRUCTION OF A 1047-BED REPLACEMENT HOSPITAL IN HOUSTON, TEXAS; $80.5 MILLION FOR A REPLACEMENT HOSPITAL IN AUGUSTA, GEORGIA; AND $82.2 MILLION FOR A CLINICAL ADDITION AND 240-BED NURSING HOME AT PHILADELPHIA, PENNSYLVANIA. IN ADDITION, A $1.6 MILLION CONTRACT WAS AWARDED LAST YEAR TO BEGIN PRELIMINARY DEVELOPMENT OF A NEW VA MEDICAL CENTER IN PALM BEACH COUNTY, FLORIDA. THE PALM BEACH PROJECT MARKS THE FIRST NEW ADDITIONAL VA MEDICAL CENTER SINCE 1973 AND PROUDLY WILL BECOME OUR 173RD VA MEDICAL CENTER. IN THE MINOR CATEGORY, THE VA OBLIGATED NEARLY $17.0 MILLION MORE IN FY 1987 THAN IT DID IN FY 1986, WHICH WAS A RECORD YEAR, AND IN THE MAJOR CATEGORY, THE VA OBLIGATED OVER $135.0 MILLION MORE THAN OUR FY 1986 OBLIGATION LEVELS. DESPITE THESE RECORD CONSTRUCTION OBLIGATIONS IN FY 1987, OUR PROJECTIONS CALL FOR AN INCREASE IN OBLIGATIONS IN FY 1988 FOR AN ESTIMATED RECORD OF $892.6 MILLION.

DURING THE PAST FIVE YEARS, WE HAVE COMPLETED NUMEROUS PROJECTS, INCLUDING 14 MAJOR HOSPITAL REPLACEMENT PROJECTS, REPLACING OLDER FACILITIES WITH STATE-OF-THE-ART, MEDICAL FACILITIES HOUSING OVER 6,100 BEDS; 27 NURSING HOMES PROVIDING 2,000 BEDS; AND TWO NEW NATIONAL CEMETERIES AT FT. MITCHELL, ALABAMA, AND PRUNTYTOWN, WEST VIRGINIA. IN ADDITION, ON MAY 29, 1988, WE WILL BE DEDICATING OUR 112TH NEW NATIONAL CEMETERY IN BUSHNELL, FLORIDA. WITH SPECIFIC REFERENCE TO NURSING HOME BEDS, IT SHOULD BE NOTED THAT BETWEEN FY 1981-FY 1988, THE VA RECEIVED MAJOR CONSTRUCTION FUNDING FOR 43 NURSING HOME CARE UNIT PROJECTS, WITH 5,000 BEDS EITHER ALREADY BUILT OR SOON TO BE IN CONSTRUCTION.

THE VA CONSTANTLY SEEKS IMPROVEMENTS IN ITS CONSTRUCTION PROGRAM, AND OVER THE PAST FEW YEARS WE HAVE UNDERTAKEN A NUMBER OF NEW INITIATIVES TO IMPROVE THE TIME, COST AND QUALITY FACTORS IN OUR CAPITAL FACILITIES PROGRAMS. HIGHLIGHTS OF JUST A FEW OF THE INITIATIVES ARE AS FOLLOWS:

- IN AN EFFORT TO COMPREHENSIVELY ASSESS AND IMPROVE THE EFFICIENCY AND EFFECTIVENESS OF THE VA'S ORGANIZATION AND PROCEDURES FOR CONSTRUCTING HEALTH CARE FACILITIES, THE VA UNDERTOOK A MAJOR CONSULTANT STUDY ("COMPREHENSIVE STUDY OF THE VETERANS ADMINISTRATION'S ORGANIZATION AND PROCEDURES FOR CONSTRUCTING HEALTH CARE FACILITIES") IN MARCH 1984 WHICH WAS COMPLETED IN APRIL 1985. THIS CONSULTANT STUDY PROVIDED A CANDID ASSESSMENT OF STRENGTHS AND WEAKNESSES IN OUR CONSTRUCTION PROGRAM AND HAS LED TO MANY INITIATIVES AND IMPROVEMENTS WHICH HAVE BENEFITED AND WILL CONTINUE TO SUBSTANTIALLY BENEFIT OUR PROGRAM IN THE YEARS AHEAD.

- FOLLOWING THIS CONSULTANT STUDY, IN AN INITIATIVE TO STREAMLINE OPERATIONS, IMPROVE ACCOUNTABILITY AND IMPROVE MANAGEMENT OF THE VA'S CAPITAL FACILITIES AND REAL PROPERTY PROGRAMS, ON JULY 25, 1986, THE ADMINISTRATOR DIRECTED THE CREATION OF A NEW OFFICE OF FACILITIES, MERGING THE FORMER OFFICE OF CONSTRUCTION AND DM&S' FACILITIES ENGINEERING, PLANNING AND CONSTRUCTION (FEPAC) OFFICE. THE OFFICE OF FACILITIES SUBSEQUENTLY WAS FORMED ON OCTOBER 1, 1986, RESULTING IN AN ORGANIZATIONAL FOUNDATION TO SUPPORT IMPROVED ACCOUNTABILITY, COORDINATION, CONTROL AND COMMUNICATION IN THE VA'S CONSTRUCTION PROGRAM. AS A RESULT OF THE REALIGNMENT AND OTHER INITIATIVES, THE STAFFING REQUIRED TO SUPPORT THE VA'S CAPITAL FACILITIES PROGRAM HAS BEEN STREAMLINED FROM 867 FTEE (FY 1984 LEVEL) TO 727 FTEE (FY 1989 REQUEST LEVEL), OR A REDUCTION OF 140 FTEE.

- THE 1984/1985 CONSULTANT STUDY ALSO MADE A SERIES OF RECOMMENDATIONS THAT ADDRESSED WEAKNESSES IN THE HEALTH CARE FACILITIES CONSTRUCTION PROCESS. THE FIRST OF THESE RECOMMENDATIONS WAS TO DEVELOP THE FACILITY DEVELOPMENT APPROACH TO PLANNING WHICH WAS REFERRED TO A MOMENT AGO. THE VA IS IN THE PROCESS OF PILOT TESTING THE FACILITY DEVELOPMENT PLANNING PROCESS AT FOUR VA MEDICAL CENTERS AND WILL COMPLETE THOSE PILOT FDP'S IN APRIL, 1988. WE ARE ALSO IN THE PROCESS OF ENGAGING A CONTRACTOR TO EVALUATE THOSE PILOT FDP'S WHICH WILL INCLUDE FEEDBACK TO IMPROVE FUTURE FDP'S. FUNDING FOR 40 FDP'S

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WAS APPROVED FROM FY 1987 FUNDS AND FUNDING FOR AN ADDITIONAL 40 FDP'S WAS APPROVED FROM FY 1988 FUNDS. PENDING THE RESULTS OF THE EVALUATION OF THE PILOT FDP'S, WE HOPE TO BEGIN PREPARING ADDITIONAL FDP'S IN LATE SPRING OR EARLY SUMMER OF THIS YEAR. IN ADDITION, WE ARE MAKING SIGNIFICANT ADVANCES IN IMPLEMENTING OTHER CORE PROCESS RECOMMENDATIONS THAT WERE MADE IN THE CONSULTANT STUDY INCLUDING EARLIER DEFINITION OF SCOPE, DESIGN PROBLEMS, DESIGN CONSTRAINTS AND MANAGEMENT REQUIREMENTS IN PROJECT PLANNING. FOR EXAMPLE, A REVISION IN OUR DESIGN APPROACH WILL BE IMPLEMENTED WITH THE FY 1988 ADVANCE PLANNING FUND PROJECTS TO EXTEND THE ADVANCE PLANNING PHASE TO A LEVEL EQUIVALENT TO 35% OF WORKING DRAWINGS WHICH WILL BETTER RESOLVE FUNCTIONAL, TECHNICAL AND SCOPE ISSUES EARLIER IN THE DESIGN PROCESS. OTHER ADVANCES INCLUDE CLOSER COORDINATION BETWEEN CONSTRUCTION PROGRAM PLANNING AND MEDICAL FACILITY PLANNING; DEVELOPMENT OF BETTER INFORMATION TO GUIDE CONSTRUCTION PROGRAM RESOURCE ALLOCATION DECISIONS ON THE NEED FOR A PROJECT; RESTRUCTURING DESIGN ACTIVITIES TO RESOLVE FUNCTIONAL AND SCOPE ISSUES EARLIER IN THE DESIGN PROCESS; DEVELOPING FUNDING STRATEGIES THAT MINIMIZE COORDINATION REQUIREMENTS BETWEEN THE CONSTRUCTION AND BUDGET PROCESSES; AND IMPROVING PROCESS LEVEL STANDARDS AND CONTROL TOOLS. THE VA IS WORKING TOWARD DEVELOPING NEW APPROACHES TO IMPROVE SPACE AND EQUIPMENT PLANNING STANDARDS. DESIGN GUIDE PLATES ARE BEING CONSIDERED TO BETTER COMMUNICATE FUNCTIONAL AND TECHNICAL

REQUIREMENTS, SUCH AS FOR SPINAL CORD INJURY UNITS. OVERALL PROCESS CONTROL APPROACHES WERE RECENTLY IMPLEMENTED THROUGH THE USE OF PROJECT MANAGEMENT PLANS FOR ALL MAJOR CONSTRUCTION PROJECTS. IN ADDITION, WE HAVE IMPLEMENTED PROCEDURES TO REVALIDATE PROGRAM PLANNING INFORMATION FOR MAJOR CONSTRUCTION PROJECTS AT CRITICAL POINTS IN THE COURSE OF PROJECT DEVELOPMENT.

o THE VA'S CAPITAL FACILITIES STUDY INITIATIVE WAS FUNDED IN FY 1984 AND INVOLVED THE FIRST COORDINATED, CENTRALLY DIRECTED STUDY OF THE PHYSICAL PLANT CONDITION OF 132 VA MEDICAL CENTERS BUILT PRIOR TO 1970. ALL OF THE STUDIES WERE COMPLETED BY THE END OF FY 1987 AND THE ANALYSIS OF THE RESULTS JUST COMPLETED IN EARLY MARCH 1988. IN SUMMARY, THE STUDIES INDICATED THAT THE VA'S PHYSICAL PLANT, PARTICULARLY GIVEN THE AGE OF MANY OF THE BUILDINGS, IS IN REMARKABLY GOOD CONDITION. THE STUDY REVIEWED VARIOUS PHYSICAL PLANT FUNCTIONS.

THE STUDIES PROVIDED RECOMMENDATIONS FOR CORRECTION OF DEFICIENCIES AND PROVIDED A MAGNITUDE ESTIMATE OF THE WORK REQUIRED TO MEET CURRENT VA STANDARDS AND CONFORMANCE TO CODE, FIRE AND SAFETY, AND JCAH REQUIREMENTS. IN AGGREGATE AND UNADJUSTED FIGURES, THE STUDIES FOUND AN ESTIMATED $1.325 BILLION NEEDED IN CORRECTIVE ACTION. HOWEVER, OF THIS AMOUNT, APPROXIMATELY 10% OF THE IDENTIFIED WORK HAS BEEN COMPLETED OR FUNDED; AND APPROXIMATELY 69% HAS BEEN PLANNED IN THE AFFECTED MEDICAL CENTER'S FIVE-YEAR CONSTRUCTION PLAN.

AS THE ANALYSIS OF THE STUDY RESULTS WAS JUST COMPLETED LAST WEEK, THE FINAL REPORT HAS NOT YET BEEN DRAFTED. AS SOON AS IT IS COMPLETED, WE WILL BE PLEASED TO SHARE A COPY WITH THE COMMITTEE. THE RESULTS OF THE CAPITAL FACILITIES STUDY ARE BEING INCORPORATED INTO THE FACILITY DEVELOPMENT PLANNING PROCESS AS WELL AS BEING USED TO ASSIST IN EVALUATING THE VIABILITY AND PRIORITY OF PROPOSED PROJECTS.

o IN ANOTHER INITIATIVE AREA, A MAJOR COST SAVINGS STUDY ENTITLED "STUDY OF VETERANS ADMINISTRATION DESIGN AND CONSTRUCTION REQUIREMENTS TO REDUCE THE COST OF FACILITIES," FOCUSED ON REDUCING THE INITIAL CONSTRUCTION COSTS FOR VA FACILITIES BY CRITICALLY ANALYZING AND EVALUATING THE VA'S DESIGN AND CONSTRUCTION REQUIREMENTS TO BETTER COINCIDE WITH COMPARABLE PRIVATE SECTOR FACILITIES. OF THE 592 TOTAL RECOMMENDATIONS IN THE STUDY, 327 STUDY RECOMMENDATIONS WERE FULLY APPROVED FOR IMPLEMENTATION AND 50 ADDITIONAL RECOMMENDATIONS WERE APPROVED IN PART BY THE VA. WHEN FULLY APPLIED TO AN AVERAGE NEW VA FACILITY, THESE IMPLEMENTED RECOMMENDATIONS WILL RESULT IN CONSTRUCTION COST SAVINGS OF APPROXIMATELY $5.4 MILLION PER AVERAGE VA HOSPITAL, $430,000 PER 120-BED NHCU, AND $1.0 MILLION PER AVERAGE CEMETERY FACILITY. THE VA ALSO EXPECTS TO ACHIEVE COMPARABLE COST SAVINGS ON PROJECTS INVOLVING MAJOR ALTERATION OR ADDITIONS TO EXISTING FACILITIES.

- IN AN EFFORT TO CONTROL MEDICAL FACILITY OPERATING COSTS, THE VA ALSO HAS ESTABLISHED AN EXTREMELY EFFECTIVE ENERGY CONSERVATION PROGRAM. BETWEEN 1975, AS A BASE YEAR, AND 1985, THE VA REDUCED ITS ENERGY CONSUMPTION IN EXISTING BUILDINGS BY OVER 21 PERCENT. IN CALENDAR YEAR 1987, THROUGH ENERGY CONSERVATION RETROFITS AND CONSERVATION MEASURES, WE REDUCED ENERGY CONSUMPTION 3.37 PERCENT OVER 1985 USAGE AND AS A RESULT SPENT $19.65 MILLION LESS FOR ENERGY THAN IN 1986.

- THE VA'S CONSTRUCTION BUDGET DEVELOPMENT PROCESS WAS SIGNIFICANTLY IMPROVED IN 1986 BY DEVELOPMENT OF A NEW METHODOLOGY TO ASSIST IN PRIORITIZING MAJOR DM&S CONSTRUCTION PROJECTS FOR FUNDING ONCE THE NEED FOR THE PROJECT HAD RECEIVED MEDIPP APPROVAL. THIS NEW PRIORITIZATION METHODOLOGY WAS FIRST USED IN FORMULATION OF THE VA'S FY 1987 BUDGET AND HAS BEEN USED IN ALL SUBSEQUENT ANNUAL CONSTRUCTION PLANNING, CONSTRUCTION BUDGET SUBMISSIONS AND DEVELOPMENT OF THE FIVE-YEAR MEDICAL FACILITY DEVELOPMENT PLAN. THE PRIORITIZATION METHODOLOGY HAS BEEN A VERY HELPFUL TOOL TO STABILIZE AND OBJECTIFY CONSTRUCTION PLANNING SCHEDULES AND TO PREPARE PROJECTS FOR BUDGET REQUESTS. A TASK FORCE HAS RECENTLY BEEN FORMED TO RECOMMEND FURTHER REFINEMENTS IN THE METHODOLOGY, AND WE WILL BE PLEASED TO SHARE THESE REFINEMENTS WITH THE COMMITTEE ONCE THE TASK FORCE HAS COMPLETED ITS WORK.

MR. CHAIRMAN, I WOULD LIKE TO NOTE THAT NEEDS BASED PLANNING IS THE CORNERSTONE OF THE VA'S FACILITY PLANNING PROGRAM. THE FY 1989 MEDICAL FACILITY CONSTRUCTION BUDGET REQUEST IS A PRODUCT OF THE PLANNING AND DEVELOPMENT EFFORTS OF THE OFFICE OF FACILITIES AND THE VA DEPARTMENTS WITHIN THE CONTEXT OF AVAILABLE BUDGET RESOURCES. IN THE CASE OF THE DEPARTMENT OF MEDICINE AND SURGERY, THE DM&S MEDICAL DISTRICT INITIATED PROGRAM PLANNING PROCESS (MEDIPP) SERVES AS THE INITIAL PROGRAMMATIC BASIS OF CONSTRUCTION PLANNING IN THE VA.

THESE PLANS, WHICH IDENTIFY MEDICAL PROGRAMS AND LEVELS OF SERVICE, ARE REVIEWED, MODIFIED, IF NECESSARY, AND APPROVED IN VA CENTRAL OFFICE. THIS SERVES AS THE BASIS FOR THE DEVELOPMENT BY EACH MEDICAL CENTER OF A FIVE-YEAR FACILITY PLAN--A PLAN WHICH IDENTIFIES FACILITY REQUIREMENTS AND PROJECTS TO CORRECT DEFICIENCIES AND TO PROVIDE THE NECESSARY PHYSICAL PLANT TO MEET PROGRAMMATIC OBJECTIVES. AS NOTED PREVIOUSLY, WE LOOK FORWARD TO THE FACILITY DEVELOPMENT PLAN INITIATIVE MAKING A SIGNIFICANT EVOLUTIONARY IMPROVEMENT IN THE USE AND REFORMATTING OF OUR NEEDS BASED PLANNING AND PRIORITIZATION SYSTEM AND RESULTING IN MORE UNIFORM, CONSISTENT PLANNING DATA AND IMPROVED DOCUMENTATION OF DECISIONMAKING.

THE MEDIPP PROCESS, THE FIVE-YEAR FACILITY PLANNING PROCESS, AND THE FDP PROCESS FOR INDIVIDUAL VA MEDICAL CENTERS UTILIZE TO A LARGE EXTENT THE EXPERTISE OF MEDICAL CENTER PERSONNEL--THE OPERATIONAL USERS OF THE FACILITIES.

THE PRIORITIZATION OF THE MAJOR CONSTRUCTION PROJECTS WHICH EMERGE FROM THIS PROCESS RELIES ON AN ESTABLISHED METHODOLOGY WHICH WAS DEVELOPED BY THE VA AT THE DIRECTION OF THE CONGRESS. IT IS A STATE-OF-THE-ART DECISION SUPPORT TOOL, AND ONE WHICH HAS WORKED VERY WELL SINCE ITS DEVELOPMENT IN 1986. THIS METHODOLOGY HAS REMOVED MUCH OF THE JUDGMENTAL DECISIONMAKING WHICH WAS REQUIRED FOR PROJECT SELECTION PRIOR TO THE METHODOLOGY'S DEVELOPMENT.

THE MAJOR PROJECTS INCLUDED IN THE BUDGET REQUEST ALSO HAVE BEEN DEVELOPED UTILIZING THE ADVANCED PLANNING PROCESS WHICH PROVIDES DETAILED DEFINITION OF NEED IN TERMS OF SPACE, FUNCTIONAL AND TECHNICAL REQUIREMENTS.

IN FULFILLING OUR COMMITMENT TO QUALITY VA HEALTH CARE FACILITIES, THE VA ALSO IS ACUTELY AWARE OF THE NEED TO NOT ONLY DELIVER THE HIGHEST QUALITY FACILITIES WE CAN, BUT ALSO AT THE BEST PRICE POSSIBLE AND IN A TIMELY FASHION. THE RECENTLY COMPLETED CONSULTANT STUDY ON REDUCTION OF THE COSTS OF VA DESIGN AND CONSTRUCTION REQUIREMENTS REFLECTS OUR CONTINUED COMMITMENT TO SEEK COST EFFECTIVE CONSTRUCTION STANDARDS AND SPECIFICATIONS. THE VA ALSO PLACES EMPHASIS ON VALUE ENGINEERING (VE) THROUGH OUR IN-HOUSE VE STAFF, RETENTION OF VE CONSULTANTS AND USE OF VE CLAUSES IN OUR CONSTRUCTION CONTRACTS. IN CALENDAR YEARS 1981 THROUGH 1987, THE VA ACHIEVED OVER $52.0 MILLION IN COST SAVINGS ON CONSTRUCTION PROJECTS THROUGH VALUE ENGINEERING, RESULTING IN A SAVINGS OF MORE THAN $24.00 FOR EVERY $1.00 SPENT ON THIS PROGRAM. IN THE AREA OF NURSING HOME CONSTRUCTION, THE VA CONTINUES TO WORK TO REDUCE OUR NURSING HOME COSTS WITH SUCH INITIATIVES AS THE PROTOTYPE

APPROVED IN FEBRUARY 1987, IMPLEMENTATION OF THE CONSULTANT STUDY COST REDUCTION RECOMMENDATIONS, AND EXPLORATION OF USE OF A BUILDING SYSTEM APPROACH TO NURSING HOME CONSTRUCTION. THESE EFFORTS TO REDUCE CONSTRUCTION COSTS WILL CONTINUE BUT NOT AT THE SACRIFICE OF QUALITY.

AS SET FORTH IN THIS TESTIMONY, WE ARE CONSTANTLY STRIVING TO IMPROVE AND REFINE OUR PLANNING, DESIGN AND CONSTRUCTION PROCESSES. OUR MISSION IN THE VA'S CONSTRUCTION PROGRAM IS TO PROVIDE TIMELY, EFFICIENT AND COST-EFFECTIVE MANAGEMENT OF AND SUPPORT TO THE AGENCY'S INTEGRATED CAPITAL FACILITIES PROGRAMS. WE TAKE THAT MISSION VERY SERIOUSLY.

MR. CHAIRMAN, I WOULD LIKE TO THANK YOU FOR THE OPPORTUNITY TO APPEAR HERE TODAY, AND MY COLLEAGUES AND I WOULD BE PLEASED TO ANSWER QUESTIONS THAT YOU OR THE OTHER MEMBERS MAY HAVE.

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ATTACHMENT A

REPORT ON A METHODOLOGY FOR PRIORITIZING MAJOR CONSTRUCTION PROJECTS IN THE VETERANS ADMINISTRATION

A JOINT PROJECT OF
FACILITY PLANNING SERVICE
AND PLANNING POLICY SERVICE

DEPARTMENT OF MEDICINE AND SURGERY

VETERANS ADMINISTRATION

JUNE 1985

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A METHODOLOGY FOR PRIORITIZING MAJOR CONSTRUCTION PROJECTS IN THE VETERANS ADMINISTRATION

Executive Summary

1. This report transmits to the Senate and House Appropriations Subcommittees for HUD-Independent Agencies and the Senate and House Veterans Affairs Committees a methodology for prioritizing Veterans Administration major construction projects (e.g., those costing $2 million or more). The report was required to be submitted to the Appropriations Subcommittees pursuant to page 93 of Senate Appropriations Committee Report No. 98-506 dated June 6, 1984, which accompanied Public Law 98-371, the 1985 HUD-Independent Agencies Appropriations Act. This methodology meets the Committee Report's requirement for a system which will more objectively rank the VA's major construction projects in a single priority list. The methodology was developed in close consultation with the committee staffs. In the future, some issues, including meeting the needs of service-connected veterans who have the highest priority for medical care, will be considered to determine the appropriateness of using such factors in construction prioritization. It must be noted however, that this system cannot and will not supplant the need for executive review by the Chief Medical Director and the Administrator to insure that circumstances and conditions which might not be addressed by the methodology are considered in formulating Agency priorities.

2. The project team that developed the methodology was composed of staff from Facility Planning Service and Planning Policy Analysis Service of the VA's Department of Medicine and Surgery (Attachment 1). Throughout the development process a wide spectrum of professional and technical expertise was used to ensure that the methodology developed was practical, reflected established policy and would meet Department and Agency needs for construction. A formal Advisory Committee chaired by the Deputy Chief Medical Director was created to assist the project team . This Committee consisted of Departmental and Agency-level executives and staff who provided a broad overview of VA's medical program, as well as knowledge of construction requirements. (Attachment 2).

3. The methodology was designed to provide several key features:

- Consistency with established program and construction policy, as found in authorizing statutes, legislative history, and Agency guidance.

- Responsiveness to changes in statute and policy. Provision has been made for an annual formal review and adjustment of priority factors, to reflect new legislation, program requirements or policy directions.

- Capacity for refinement as new data, additional criteria, or improved project scoring procedures are developed.

- Potential for adaptation and application to additional lists of construction projects, in order to further support systematic facility, budgetary and program planning.

- Attention to the important considerations in facility planning: policy emphases, a balance in the importance given to the various kinds of facilities which are essential in a comprehensive medical care system, and the relative facility deficiencies and program requirements.

- Explicit criteria systematically and objectively applied. The basis for VA medical facility construction priorities will be clear to those who have a responsibility or an interest in reviewing VA construction programs.

- Ease of understanding. Simple, straight forward mathematical procedures were applied in order to facilitate explanation, application, direction and future improvement of the methodology.

4. The methodology has two principle stages whereby panels of experts met to determine the relative importance of specific criteria within and among project types.

a. Each project is evaluated and scored according to criteria pertinent to the type of project (e.g., Clinical Improvement, Outpatient, Laundry, Fire and Safety). The criteria, weights and scoring procedure for each project category are described in Appendix A. These criteria address items such as workload, functionality, space deficiencies and other factors specific to each category. The criteria and their relative importance (their weight) were developed by panels of DM&S professional and technical experts representing the appropriate disciplines (Attachment 3). These criteria rely, in many cases, on data and judgments gathered from other ongoing processes within the VA, including MEDIPP, reviews by the Joint Commission on Accreditation of Hospitals, systematic external review process reports, fire/safety equivalency evaluation surveys, and other studies done on a regular basis. A panel of raters is formed for each project to evaluate and score the project. These raters will be those individuals in VA Central Office DM&S and Office of Construction and the VAMC who are most familiar with the individual VAMC and the project. This evaluative process results in a rank ordering of projects within each of their respective construction categories.

b. The second part of the methodology, described in Appendix B, involves integrating the projects from all the major construction categories into a single prioritized list. During this process each construction project's score is first standardized on a ten point scale, then multiplied by a program emphasis weighting factor that reflects the department's construction and program policies. This procedure results in the final score which determines a project's standing in the priority list. The program weighting factors were developed by a panel of DM&S and Agency executives (listed in Attachment 4) with a broad knowledge of DM&S construction and program needs. In summary, the resultant priority list addresses two levels of importance. First, the ranking of projects within their respective categories is based on the number and degree of "deficiencies" or needs addressed by each project, as compared with similar projects. Secondly, overarching DM&S policy considerations are factored into the prioritization process by weighting certain programmatic areas more than others. A sample priority listing of projects against which the methodology was tested is found in Attachment B-4 to Appendix B.

5. It is important to note that this prioritization methodology was designed to distinguish among VA construction projects in terms of their relative importance. It is not designed to justify the need, size or function of projects. These questions relating to the basic justification for facility construction must be determined through the appropriate processes of policy development, program planning and architectural or engineering design. It should also be noted that various construction projects have differing levels of complexity in their development. Thus, some projects take longer to bring to a budget ready status than others and for that reason it is sometimes necessary to delay from budget consideration, higher priority projects which are simply not ready to be introduced into the budget process.

6. The Department of Medicine and Surgery plans to use this prioritization methodology as a major management tool in determining the relative importance of individual major construction projects and in establishing priorities. Presently, the methodology is best suited for application to projects which have completed the advance planning process and are ready for budget consideration. This is because at the completion of advance planning, the data needed for the use of the methodology is most readily available given existing data systems. The methodology can, however, be used in a modified way at this time in making judgments regarding projects which have not completed advance planning by collecting data, as needed, about the projects. The Department of Medicine and Surgery will be taking the necessary steps to gather the data necessary to use this methodology as part of the facility planning process. Thus, in the future this methodology can be more readily used in the development of individual medical center facility plans, the annual Medical Facility Construction Needs Assessment, and the selection of projects to enter the APF process. In the future, when a project is initially identified for consideration and planning purposes, the project will be scored using this methodology to assess its relative importance against all other projects. Appendix C describes the VA's plans to implement the methodology. These plans will result in formalized procedures which will assure accountability, accuracy, reliability, and the application of necessary program and technical knowledge in the process. One concern of DM&S is that the methodology be reviewed on a regular basis and updated as necessary to

reflect changes in program or policy, modification in the planning process, and the availability of any new criteria or data. A formal review will take place on an annual basis to consider these matters and make any necessary updates.

7. Questions about the methodology or its application may be addressed to the Department of Medicine and Surgery's Facility Planning Service (202) ~~389-2452~~.
233-3804

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Attachment 1

Project Team For Development of Major Construction Prioritization Methodology

Mr. Robert L. Neary, Director, Facility Planning Service, Co-Chairman
Mr. James H. Gregg, Deputy Dir., Program Analysis and Development, Co-Chairman
Mr. Stephen J. Hecht, Supervisor, Planning Policy Service, Team Leader
Mr. Charles F. Krewson, Deputy Director, Facility Planning Service
Mr. James P. Cody, Facility Planning Service
Mr. Kraig W. Cummings, Planning Policy Service
Mr. Gary J. Greene, Planning Policy Service
Dr. Dolores Swearingen-Archer, Planning Policy Service

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Attachment 2

Advisory Committee on Major Construction
Prioritization Methodology Project

Deputy Chief Medical Director, Chairperson
Resource Management, Deputy Director (10A2)
Facility Engineering, Planning and Construction, Director (10A4)
Program Analysis and Development, Director (10C)
Associate Deputy Chief Medical Director (10B)
Deputy Regional Director, Northeastern Region (10BA1)
Professional Services, ACMD (11)
Administration, ACMD (13)
Academic Affairs, ACMD (14)
Research and Development, ACMD (15)
Geriatrics and Extended Care, ACMD (18)
Office of Construction, Program Control and Analysis Staff, Director (08D)
Office of Budget and Finance, Construction Division Chief (041C)
Office of Planning and Program Evaluation (07)
Director, VAMC Dallas

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Attachment 3

Professional/Technical Representation For Major Construction Category Criteria and Weighting Development

Department of Medicine and Surgery:

- Office of Facility Engineering, Planning, Construction
- Office of Program Analysis and Development
- Medical Service
- Nursing Service
- Dietetic Service
- Social Work Service
- Office of Research and Development
- Office of Academic Affairs
- Office of Geriatrics and Extended Care

Office of Construction:

- Health Care Facilities Service
- Estimating Service

Attachment 4

PANEL FOR DETERMINING PROGRAMMATIC EMPHASIS WEIGHTS

February 26, 1985

1. **Susan Livingstone:** Associate Deputy Administrator for Logistics
2. **Conrad Hoffman:** Director, Office of Budget and Finance
3. **William F. Delamater, representing Carl W. Hughes, M.D.:** ACMD for Professional Services, DM&S
4. **Arthur J. Lewis, M.D.:** Deputy Assistant Chief Medical Director for Professional Services, DM&S
5. **Alvin B. Carr, Jr.:** Director, Region 3, DM&S
6. **Albert Zamberlan:** Director, Region 4, DM&S
7. **Malcolm Randall:** Director, VAMC Gainesville, FL
Director, Medical District 12
Chairman, Field Advisory Council
8. **John J. Lee:** Director, Facility Engineering, Planning, Construction Office, DM&S
9. **C. Wayne Hawkins:** Director, VAMC Dallas, TX
Chairman, Subcommittee on Construction, Field Advisory Committee
10. **Gerald E. Neumann:** Director, Program Control and Analysis Staff, Office of Construction
11. **Barbara Small:** Director, VAMC Boston, MA
12. **Richard F. Falco:** Deputy Director, Facility Engineering, Planning, Construction Office, DM&S
13. **Samuel Threefoot, M.D.:** Chief of Staff, VAMC New Orleans, LA

Prioritization of Projects Within Their Major Construction Category

Description: The pages in this appendix describe in detail, for each major construction category, the following:

1. The definition of the construction category.
2. The criteria definitions.
3. The relative importance of the criteria (their weight) within each category.
4. The data sources that will be used to gather the information needed to score the project against the criteria.
5. The actual application of questions used to determine the degree of deficiency being corrected by the project for each of the category specific criteria.
6. An example of how projects would be scored under each category.
    a. The scoring process was designed to use as much objective data as is available and will be updated as additional objective data becomes available. Where subjective data are used, a scoring range (i.e., 1-10) is used to help ensure that subjective decisions, based on professional judgement, are kept within the desired parameters.
    b. After each project is scored against each of the criteria in its category the score is multiplied by the applicable criteria weight. This results in a weighted score for each criteria.

c. Where a construction project consists of more than one project category (e.g., Replacement/Modernization or Clinical Improvement/Outpatient addition), the project will be divided up into its component category parts based on the information available. Each component will be scored independently, and the component scores combined based on the percentage each component is of the total project scope. The largest component in terms of percentage, determines the overall category to which the project is assigned and to which all subsequent calculations will be applied.

d. The final step is to sum the weighted scores of all the criteria for a given project. This score is used for ranking projects within their major construction category. However, if a project is a combination of several component categories, it will be necessary to standardize the weighted scores for all projects before ranking within the category. Standardization procedures are explained more fully in Appendix B.

ADMINISTRATIVE PROJECTS

A. Category Descriptions: Administrative projects are planned to provide appropriate space to allow for efficient functional operation of the supportive administrative services. In many cases, the need to expand clinical services in the medical center encroaches on administrative space. Although some administrative services must be physically adjacent to one another or to a related clinical service, many of the administrative services can function in space which is not physically linked to the clinical services of the medical center. By constructing a new building or by renovation of an existing building, administrative functions can be consolidated and the vacated space in the medical center can be designated for use by direct patient care services.

B. Criteria Descriptions: The prioritization process for these projects consists of the review of three areas:

1. Space Deficiencies: After determining which administrative services are to be affected by the project, an analysis is undertaken to determine percent deficiency with regard to current space for program vs. projected need for space. To develop a priority rank for these projects at different VAMC's, a comparison is made of only those services germane to each project. The more space deficiency, in the aggregate, that a project exhibits, the higher the ranking under this criteria.

2. Functionality: Using the VA's Space and Functional Deficiency Identification (SFDI) System for affected services, the functional arrangement or layout of a particular service is scored. The higher the score, the worse the functional layout and the higher the priority rank. Another factor under functionality is the adjacency of a particular service to another. An example is the nearness of Supply and Fiscal Services to each other. The more unacceptable the adjacency, the higher the rank.

3. Domino Effect: The relocation of an administrative service (in order to improve its condition) may result in the vacant space being used for clinical/support functions. More weight will be given to this type of project, as opposed to a project where this does not occur.

C. Criteria Weights:

Criteria	WEIGHT
1. Space Deficiencies	9
2. Functionality	5
3. Domino Effect	7

D. Data Sources:

1. SERP/JCAH Reports
2. Space and Functional Deficiency Identification System
3. H-08-9, Space Planning Criteria for VA Facilities

E. Scoring: (Attached)

ADMINISTRATIVE

		A		B	
	WEIGHT	SCORE	WTD. SCORE	SCORE	WTD. SCORE
A) Space Deficiencies	9	10	90	9.7	87.3
B) Functionality	5	.93	4.65	2.6	13
C) Domino Effect	7	10	70	10	70
TOTAL	21		164.6		170.3
STANDARDIZED SCORE			7.84		8.11
RANK			2		1

Space Deficiencies

- Use similar methodology as used for Clinical Improvements. Determine which administrative services are to be affected by project.
- Determine percent deficiency with regard to current space for program vs. projected needs for space.
- Multiply answer by ten to determine points under each program area.
- Divide total points for each medical center's program areas by number of programs evaluated under project. This determines score for this criteria.

Functionality

- Evaluate each program area under the project by applying the following questions:

• SFDI functional component score	0-.99 1 point	1.0-1.99 2 points	2.0-2.99 3 points	3.0-3.99 4 points	4.0-5.0 5 points
• Adjancies to services associated with that program.	Acceptable 1 pt.	Mid-Point 2 pts.	On average Acceptable 3 pts.	Mid-Point 4 pts.	Totally Unacceptable 5 pts.

ADMINISTRATIVE (Continued)

- Add resulting scores for each program area.
- Divide total of all program scores for individual projects by number of programs evaluated under the project.

Domino Effect

If one of the primary results of the project will be that the space vacated by the relocation of administrative offices will be utilized for clinical/support functions, there is a domino effect. The project will receive 10 points. If no domino effect, only 1 point will be scored.

BOILER REPLACEMENT PROGRAM

A. CATEGORY DESCRIPTION: Boiler Plants are a key element in the operation of VA medical facilities. The cost of boiler plant operation is a major expense item that continues to escalate rapidly. The primary objectives of the Boiler Replacement Program are the timely replacement and retrofit, efficient operation and maintenance of boiler plant equipment, and the production of the required steam safely, reliably and economically. Boiler plants provide steam for the following purposes:

- Heating Buildings
- Sterilizing Equipment
- Steam Tables in Kitchens
- Hydrotherapy
- Domestic Hot Water
- Air Conditioning Equipment
- Laundry Equipment

B. Criteria Descriptions: The criteria/priority process for the Boiler Replacement Program consists of the review of four key areas:

1. Age: A standard milestone used is an age over 30 years. Also evaluated is whether spare parts are available to repair and maintain the existing equipment, regardless of age.

2. Capacity: Under this criteria an evaluation is made as to the current base load placed upon the existing boiler. Into this base load must then be factored the projected increase load per additional structure in the future. The sum of these calculations is then compared to the existing capacity of the boiler in order to determine how deficient the equipment is. Another analysis point is the availability of a backup boiler during the peak demand season (winter months) and its correlation with existing capacity.

3. Operational Efficiency: After 20 years of operation, an evaluation of each boiler plant is made to determine if replacing the burners, controls, instrumentation and peripheral equipment is required. This technical evaluation consists of the areas identified under Section E below.

4. Condition of Physical Plant: After major boiler equipment has been in service for at least 30 years, a technical evaluation is made by the VA and an independent firm to determine the need for replacing some or all of the equipment. This differs from the operational efficiency evaluation in that the structural integrity of the existing equipment is evaluated. The areas of evaluation are identified under Section E below.

C. Criteria Weights:

Criteria	Weight
1. Age	5
2. Capacity	7.5
3. Operational Efficiency	7.5
4. Condition of Physical Plant	10

BOILER REPLACEMENT PROGRAM (Continued)

D. Data Sources:

1. Section 2.05, VA Engineering Manual MP-3, Boiler Replacement Program
2. National Fire Protection Agency - 1985, Boiler Criteria
3. Form 1193
4. Five-Year Plan

E. Scoring: (Attached)

BOILERS

CRITERIA	WEIGHT	A SCORE	A WTD. SCORE	B SCORE	B WTD. SCORE
A) Age	5	10	50	6	30
B) Capacity	7.5	4	30	2	15
C) Operational Efficiency	7.5	5	37.5	3	22.5
D) Condition of Physical Plant	10	6.4	64	2.7	27
TOTAL	30		181.5		94.5
STANDARDIZED SCORE			6.05		3.15
RANK			1		2

Age:

• Outdated Equipment (more than 30 years old)	Yes (5 points)	No (1 point)
• Spare Parts Available	Yes (1 point)	No (5 points)

TOTAL POINTS = SCORE

Capacity:

- Load Increase: Base Load + Increase load per additional structure ÷ current capacity X 10

• Spare Boiler Available During Winter Months	Yes 1 point	No 10 points

TOTAL POINTS ÷ 20 (MAXIMUM POINTS) X 10 = SCORE

BOILERS (Continued)

OPERATIONAL EFFICIENCY:

- Operational Requirements: Current maximum operational efficiency ÷ maximum operational efficiency upon completion of project X 10

	Low Defic./ Acceptable 1 pt.	Mid-Point 3 pts.	Moderately Deficient 5 pts.	Mid-Point 7 pts.	Seriously Defic./ Not Acceptable 10 pts.
• Boiler Plant Efficiency Reports					
• Boiler Plant Unit Cost Data					
• Orsat Readings					

- Steam Generated/1000 square feet annual *
- Total Operating Costs (M&R plus operations)*

* Under each of these two questions, points will be assigned to the ranked projects by assigning 1 point to the lowest ranked project (lowest steam generated/1000 square feet and or greatest $ amount in operating costs) and 10 points to the highest (highest steam generated/1000 square feet and/or least $ amount in operating costs). When comparing more than two projects, the following table will be used to assign points to the projects falling in a relative rank order between the highest and lowest rank project.

	LOW RANK				INTERMEDIATE RANK				HIGH RANK
3 projects	1				5				10
4 projects	1		4				7		10
5 projects	1		2.5		5		7.5		10
6 projects	1	2		4		6		8	10

TOTAL POINTS ÷ 60 (MAXIMUM POINTS) X 10 = SCORE

BOILERS (Continued)

CONDITION OF PHYSICAL PLANT:

	Low Defic./ Acceptable 1 pt.	Mid-Point 3 pts.	Moderately Deficient 5 pts.	Mid-Point 7 pts.	Seriously Defic./ Not Acceptable 10 pts.
• Structure: (For this section add scores - 4) Roof Windows Walls Ventilation					
• Extent of Maintenance Required					
• Boiler Down Time					
• Non-Destructive test results (Ex. Fire Brick, Chamber Floor, Exterior Brick, Forced Draft, Induced Draft Status; condition of burner unit (ignition and combustion); condition of support, condensate return and fuel oil supply pumps).					

- CODE COMPLIANCE:
  (For this section add scores - 2)

	Compliance 1 pt.	Mid-Point 3 pts.	Moderately Deficient 5 pts.	Mid-Point 7 pts.	Substantial Non Compliance 10 pts.
• ASME (American Society of Mechanical Engineers) Boiler Pressure Code					
• NFPA Code for Boilers					
• Control System Life Expectancy					

TOTAL POINTS ÷ 60 (Maximum Points) X 10 = SCORE

CLINICAL IMPROVEMENT PROJECTS

A. Category Description: Clinical improvement projects are planned to provide enough space to allow for efficient functional operation of those services relating to direct patient care. Such direct patient care services include ancillary and support services. Due to the dynamic nature of health care delivery with its new techniques, expansions and reconfigurations become necessary to allow for the latest equipment or treatment modalities. The prioritization process for these projects consists of the review of four areas:

B. Criteria Descriptions:

1. Professional Delivery Capability: A medical center which has a clinical improvement project planned that has an excellent potential to recruit and retain professionals and has a strong affiliation with a medical school would be rated higher than a medical center that doesn't. While this would tend to favor tertiary, acute care facilities, there is a third factor to be added under this criteria, compatibility with the medical center's long range mission. If a facility (regardless of affiliation or desirablity) has a clinical improvement project which will enhance health care delivery relating to the mission (as determined by MEDIPP), a higher score will be given. Also if it is determined that non-accomplishment of a particular project would hamper the facility's ability to meet its projected mission, a higher score would result. This criteria would allow for parity among affected VA medical centers regardless of size, location and current health care delivery methods.

2. Workload: All planned clinical improvement projects will be broken down into the individual services (Radiology, Laboratory, Pharmacy etc.). For each service, a measure of workload (patients treated, outpatient visits etc.) would be assigned. Based on these workloads, the space requirements (both current and projected) for an affected service are determined and a percent deficiency as compared to projected space needs is arrived at. Using different weights for direct patient care services, ancillary services and support services, scores are assigned. Those facility's that are most deficient, in the aggregate, will receive higher scores.

3. Functionality: There are several factors to be taken into consideration to determine functionality or, the functional arrangement or layout of a particular service. Using the VA's Space and Functional Identification (SFDI) System for affected services, the aformentioned functional arrangement or layout of a particular service is scored. The higher the score, the worse the functional layout and the higher the priority rank. Another factor under functionality is the adjacency of a particular service to another. An example is the nearness of laboratory service to surgical service. The more unacceptable the adjaceny, the higher the rank. The third factor relating to functionality is accessibility for patients and staff. Services such as Radiology and Rehabilitation Medicine need to be accessible to the patients who need this care and the staff who provide this care. A gross score is arrived at by combining the sub-scores of the subfactors under this criteria.

CLINICAL IMPROVEMENT PROJECTS

4. Physical Deficiencies: With regard to the overall areas covered by the project compliance or non-compliance with life safety codes, patient privacy codes and handicapped access codes are analyzed. Those with a lesser degree of compliance receive a higher ranking. If a facility has not had major expansion or modernization within the last ten years it would receive a higher rank than a facility that has. If a building included in the project is over 40 years old it would receive a higher rank. Serious overall deficiencies in the physical plant (Electrical, HVAC, Plumbing, Gas, etc.) receive higher consideration as will a facility with an affected area cited by the Joint Commission on Accreditation of Hospitals (JCAH) or by other professional accreditation bodies.

C. Criteria Weights:

Criteria	Weight
1. Professional Delivery Capability	3.8
2. Workload	9.4
3. Functionality	8
4. Physical Deficiency	9.6

D. Data Sources:

1. H-08-9 Space Criteria
2. Internal and External Reviews (JCAH, SERP, AALC)
3. MEDIPP Planning Efforts
4. VA ACMD for Academic Affairs (pertaining to affiliations)
5. SFDI

E. SCORING: (Attached)

CLINICAL IMPROVEMENTS

CRITERIA	WEIGHT	A SCORE	A WT. SCORE	B SCORE	B WT. SCORE	C SCORE	C WT. SCORE
A) Professional Delivery Capability	3.8	7	26.6	3	15	7	26.6
B) Workload	9.4	9	84.6	8.3	78	10	94
C) Functionality	8	4	32	4.9	39.2	2.8	22.4
D) Physical Deficiency	9.6	8.7	83.52	7.4	71.04	6.1	58.56
TOTAL	30.8		226.7		203.2		201.5
STANDARDIZED SCORE			7.36		6.54		6.48
RANK			1		2		3

Professional Delivery Capability

Potential for Recruitment/Retention of Professionals	Undesirable 1 Pt.	Moderate 5 Pts.	Highly Desirable 10 Pts.
Medical School Affiliation (Using determination assigned by Academic Affairs (14))	None 1 Pt.	Nominal < 2 Pts. 3 Pts. >	Strong < 4 Pts. 5 Pts. >

Compatibility with VAMC Long-range mission - Will this project contribute significantly to the MEDIPP - determined, future mission of the VAMC? Conversely, will the non-accomplishment of this project have a negative impact on the VAMC ability to provide the quality health care associated with the designated mission. As determined by professional judgement, an affirmative answer will receive 10 points. No impact will receive 1 point.

TOTAL POINTS = SCORE ÷ 25 (MAXIMUM POINTS) X 10 = SCORE

Workload
1) Determine patients treated and outpatient visits (current and projected) for VAMCs under consideration.
2) See chart for specific program areas and which measure of workload should be used.
3) Determine square footage required (total) for the workload as applied to each program area.
4) Determine % deficiency with regard to current space vs. projected space needs. Multiply this answer by 10.

CLINICAL IMPROVEMENTS (Continued)

5) Weight points assigned according to accompanying rule: Weight 3 for direct patient care services, Weight 2 for patient care ancillary services and Weight 1 for patient care support and administrative services. Multiply percent deficiency by applicable weight..

6) Divide the total weighted points for each VAMC project by the sum of all weights assigned to programs under project.

7) Score for this project is the result obtained under step 6.

Functionality

1) Using the list of program areas covered under the scope of each project in question, determine the quantified answer to each of the following questions:

• Adjacencies to services associated with that program.	Acceptable 1 pt.	Mid-Point 2 pts.	On/Average Acceptable 3 pts.	Mid-Point 4 pts.	Not Acceptable 5 pts.
o SFDI functional component score.	0-.99 1	1.0-1.99 2	2.0-2.99 3	3.0-3.99 4	4.0-4.99 5
• Accessibility for patient & staff.	Acceptable 1 pt.	Mid-Point 2 pts.	On/Average Acceptable 3 pts.	Mid-Point 4 pts.	Not Acceptable 5 pts.

2) Add resulting scores under each question for individual programs. Maximum score will equal 15.

3) Divide each score from no. 2 by 15. Multiply this answer by 10.

4) As in step 5 under "workload", multiply program scores by the appropriate weights. Add up all weighted scores for project.

5) Divide the total weighted points for each project by the sum of all weights assigned to programs under project.

6) Score for this project is the result obtained under step 4.

CLINICAL IMPROVEMENTS (Continued)

Physical Deficiencies

With regard to the overall areas covered by the project being evaluated, the following questions should be answered:

	Substantial Non Compliance 10 pts.	Mid-Point 7 pts.	Moderate/Avg. Compliance 5 pts.	Mid-Point 3 pts.	Overall Compliance 1 pt.
Life Safety Compliance Patient Privacy Code Compliance Handicapped Access Code Compliance					
Major Expansion/Modernization within last 10 years	Yes (1 pt.)				No (10 pts.)
Age of Building(s) Involved Over 40 Years	Yes (10 pts.)				No (1 pt.)
	Serious Overall Defic. 10 pts.	Mid-Point 7 pts.	Overall Avg. Defic. 5 pts.	Mid-Point 3 pts.	Overall low Level Defic. 1 pt.
Other Plant Deficiencies (Electrical, HVAC, Plumbing, Gas, etc.)					
	All Program Areas Cited as Defic. 10 pts.	Mid-Point 7 pts.	Half of Programs Cited 5 pts.	Mid-Point 3 pts.	Number of Programs Cited 1 pt.
Cited by JCAH and/or other professional accreditating bodies.					

TOTAL POINTS ÷ 70 (MAXIMUM POINTS) X 10 = SCORE —

PROGRAM AREA WEIGHTS

Direct Patient Care - Weight 3

- Ambulatory Care
- Audiology and Speech Pathology
- Cardiology Labs
- Dental
- Dialysis
- Drug Treatment
- Ear, Nose, Throat
- Eye
- Laboratory
- Nuclear Medicine
- Nursing Units
- Pharmacy
- Radiology
- Respiratory Care
- Medicine
- Neurology
- Intermediate
- Spinal Cord Injury
- Surgery
- Psychiatry

Patient Care Ancillary Services - Weight 2

- Dietetics
- Psychology
- Rehabilitation
- Social Work
- SPD

Support and Administration - Weight 1

- Building Management
- Laundry
- Canteen
- Chaplain
- Clinical Services Administrati
- Day Hospital
- Library
- Parking
- Recreation
- Voluntary Service
- Engineering
- MAS

MEASURES OF PROGRAM WORKLOAD

Bed Dependent Services (A)	Bed Independent Services (B)	Both
* Patients Treated (Patient Days) ÷ Current Support Capability	* Outpatient Visits ÷ Current Support Capability	(A + B) ÷ 2
Building Management	Ambulatory Care	Clinical Service Admin.
Canteen	Audiology and Speech Path.	Drug Treatment
Chaplain	Day Hospital	Ear, Nose, Throat
Cardiology Labs	Dialysis	Eye
Dental	Parking	Laboratory
Dietetics		Nuclear Medicine
Library		Nursing Units
Recreation		Pharmacy
Respiratory Care		Psychology
SPD		Radiology
Warehouse		Social Work
Voluntary		Medicine
Intermediate		Psychiatry
Spinal Cord Injury		Neurology
		Surgery

DIETETIC PROJECTS

A. Category Descriptions: Dietetic construction projects are those which are planned to improve or replace the area(s) of a medical center involved in the preparation and distribution of patient meals.

B. Criteria Descriptions: The prioritization of such projects is determined by:

1. Functionality: Evaluating the existing food production and distribution system as it relates to the efficiency of operation.

2. Physical Deficiency: The actual plant structure is evaluated in terms of existing life safety code, utilities and structural deficiencies.

3. Equipment: Under this criteria, the age of the existing dietetic facility whether it is part of the major hospital or a separate structure, as well as the equipment, is evaluated to determine its appropriateness for continued use to meet the current and projected peak meal workload of the medical center.

4. Workload: Projected meals served per year as compared with current meals served per year. This criteria will only be used if there is a projected increase of 20 percent or greater in workload.

C. Criteria Weights:

Criteria	WEIGHT
1. Functionality	7.4
2. Physical Deficiency	7.5
3. Equipment	6.8
4. Workload	9.6

D. Data Sources:

1. MEDIPP Workloads
2. SERP/JCAH Reports
3. H-08-9, Space Planning Criteria for VA Facilities
4. Equipment Replacement Schedules

E. Scoring: (Attached)

DIETETICS

A-30

		A		B	
	WEIGHT	SCORE	WTD. SCORE	SCORE	WTD. SCORE
A) Functionality	7.4	8	59.2	10	74
B) Physical Deficiency	7.5	5.75	43.12	4.25	31.9
C) Equipment	6.8	4	27.2	6	40.8
D) Workload	9.6	1	9.6	1	9.6
TOTAL	31.3		139.1		156.3
STANDARDIZED SCORE			4.44		4.99
RANK			2		1

A) 'nality

	Yes	No
• Distance from service area to patients causes inability to keep meals hot.	10 points	1 point
• Satellite dining areas needed due to number of remote patient buildings	10 points	1 point
• Patient access limited due to excessive distance from patient buildings to existing dining areas	10 points	1 point

[illegible] (Continued)

• Multi-level/foor operations that hinder efficient delivery	Yes 10 points	No 1 point
• Space in excess of program needs causes inefficiencies in operations.	Yes 10 points	No 1 point

TOTAL POINTS ÷ 50 (MAXIMUM POINTS) X 10 = SCORE

B) Physical Deficiency

• Compliance with Safety Code regulations.	Substantial Non-Compliance 10 pts.	Mid-Point 7 pts.	Moderate/Avg. Compliance 5 pts.	Mid-Point 3 pts.	Total Compliance 1 pt.
• Structural deficiencies (ex. need for roof and wall repairs), poor loading dock facilities.	Unacceptable 10 pts.	Mid-Point 7 pts.	On-Average Acceptable 5 pts.	Mid-Point 3 pts.	Acceptable 1 pt.
• Handicapped access deficiencies.	Serious Deficiencies 10 pts.	Mid-Point 7 pts.	Moderate Deficiencies 5 pts.	Mid. Point 3 pts.	No. Deficiencies 1 pt.
• Other utility deficiencies.	Serious Deficiencies 10 pts.	Mid-Point 7 pts.	Moderate Deficiencies 5 pts.	Mid. Point 3 pts.	No. Deficiencies 1 pt.

TOTAL POINTS ÷ 40 (MAXIMUM POINTS) X 10 = SCORE

DIETETICS (Continued)

C) Equipment

This criteria will be measured in a somewhat indirect manner by determining the age of the kitchen and dining facilities or the building(s) housing these areas. If it is determined that the Dietetics equipment has been properly maintained according to an established maintenance/replacement schedule, than the greater the age of the building, the higher will be the rank under this criteria. Points will be assigned by means of the following table:

Age in Years	10-20	21-30	31-40	41-50	>50
	2 points	4 points	6 points	8 points	10 points

D) Workload

This criteria will only be applied if there is a projected 20 percent increase in the future workload (meals served per year) of the facility in question. If such an increase is projected, this project will be assigned 10 points. If less then 20 percent, this workload criteria is considered to be not significant and will result in 1 point.

DOMICILIARY PROGRAM

A. Category Description: A domiciliary provides to eligible ambulatory veterans continuing medical care in a therapeutic institutional environment including rehabilitative assistance and other therapeutic measures. Although a domiciliary provides less intensive care than a hospital or nursing home care unit, as measured by the required intervention of a nurse and or physician, it provides a higher level of care than in a residential care setting. The focus of care is preparing the veteran to function at his or her highest level of independence; the ultimate goal is the return of the veteran to independent functioning in the community.

B. Criteria Descriptions:

1. Functionality: This criteria is subdivided into a study of (1) Adjacency of Support Services - The present DOM's relation to Dietetics, Lab, Radiology, etc. (2) Staff Accessibility - Location of nursing station, nursing offices, and support services with regard to staff useability and the provision of medical services in the present DOM, and (3) Nursing observability - Can all the rooms be observed from the nursing station and offices?

2. Physical Deficiencies: This criteria is subdivided into (1) Life/Safety Deficiencies - Safety deficiencies noted by JCAH or safety inspections. (2) Handicapped Access - Wheelchair ramps, wheelchair width doors, bathrooms, etc. (3) Patient Privacy - In the present DOM are all rooms two-person rooms; do any large multi-bed (3+) rooms exist; what are the conditions of bathing and toilet facilities, (4) Other Plant Deficiencies - Electrical, HVAC, Elevator, etc.

3. District Unmet Need: This criteria assigns ranks to all districts within a specified planning year, according to the absolute change between current and projected beds and also assigns ranks to all districts according to percent of current unmet need with regard to current versus projected. Unmet need is for VA domiciliary beds only. The need for VA domiciliary beds is determined by MEDIPP which also determines the number of state beds which will be used to meet the veteran requirements.

In new presence DOM's (where no DOM beds exist, or where the new project does not impact on present DOM beds), only the district unmet need criteria is used. Where the new DOM project replaces or modernizes the present DOM beds, all three criteria are used.

C. Criteria Weights:

Criteria	Weight
1. Functionality (Replacement/Renovation Only)	7.3
2. Physical Deficiency (Replacement/Renovation Only)	9.8
3. District Unmet Need	9.0

D. Data Sources:

1. Functionality: JCAH, SERP

2. Physical Deficiencies: FSES (Fire Safety Evaluation System, Studies), JCAH Surveys, Annual Inspection of the Regional Safety and Fire Protection Engineer
3. MEDIPP

E. Scoring: (Attached)

DOMICILIARY

CRITERIA	WEIGHT	A SCORE	A WT. SCORE	B SCORE	B WT. SCORE
A) Functionality	7.3	7	51.1	4	29.2
B) Physical Deficiency	9.8	7.75	75.95	7.75	75.95
D) District Unmet Need	9.0	2.8	25.2	6.4	57.6
TOTAL	26.1		152.25		162.75
STANDARDIZED SCORE			5.83		6.24
RANK			2		1

Determination of scores under each criteria is identical to methodology used for the Nursing Home Care criteria.

EDUCATION PROJECTS

A. Category Description: Education facilities are necessary for the instruction of patients in their treatment programs, continuing education of medical center professional and administrative staff members, and the training of house staff and students from affiliated institutions such as schools of medicine, dentistry, nursing and allied health. Education facilities include classrooms, conference rooms, libraries, medical media production facilities, study and office areas, as well as administrative space associated with training programs.

B. Criteria Descriptions and Special Considerations:

Education facilities are of maximum value when located in or near work areas where residents, students, etc. are assigned.

For this reason, education facilities are nearly always included as part of major projects funded under categories other than education or in combination with other project categories such as clinical improvement or research. The presence of education facilities in a major construction project, in a category other than education, entitles that project to consideration of deficiencies of education facilities in the overall ranking of that project. Rarely are separate projects for education facilities considered or planned as part of the major construction category. When this does occur, or if a major component of a major project includes includes Education work, the following criterion will apply:

Adequacy of existing education facilities vs. planned number and type of trainees in various program (residents, medical students, allied health trainees, medical center staff, patient education) will determine the amount of space needed to accomodate this workload.

C. Criteria Weights:

Criteria	Weight
Space Deficiency	10

D. Data Sources:

- H-08-9, Space Planning Criteria for VA Facilities

E. Scoring: $1 - \frac{\text{Current Space}}{\text{Projected Future Space}}$ X 10 = Percent Deficiency Score

- The weighted score under this category would then be added into, on a percentage basis, the multiple-category project in which there is an "Education" Component.

ELECTRICAL

A. Category Description: All electrical systems are carefully monitored as part of a regular maintenance program. Professional testing, inspection, adjustment and maintenance of the major components of the electrical system are conducted every three years. Annual evaluations are also conducted of the secondary distribution systems and branch circuits. There are also periodic tests of the primary distribution systems and there are capital facilities studies being conducted for all but the newest medical centers. Given this regular and thorough inspection and maintenance program, electrical deficiencies are usually corrected as nonrecurring maintenance, minor miscellaneous, minor, or in association with other projects. However, where separate electrical major projects are developed, the following criteria are used.

B. Criteria Descriptions:

1. Condition: Code violations, number of outages, problems with service or parts, safety hazards, etc., are considered in this category.

2. Capacity: An evaluation of any significant existing deficiencies or forseeable increases in existing capacity is conducted.

3. Age: Typical service life for most electrical systems and components is 20 to 30 years. After 30 years, a major upgrading needs to be considered.

4. Operational Efficiency: Excessive loss due to low voltage or low power distribution, and the need for co-generation and the reduction of utility costs as a result of the project are considered in this category.

C. Criteria Weights:

Criteria	Weight
1. Condition	10
2. Capacity	7.25
3. Age	5
4. Operational Efficiency	7.5

D. Data Sources: Electrical Survey Conducted by A/E and Form 1193 (Project Submission) are main sources of data about electrical needs.

E. Scoring: (Attached)

ELECTRICAL

CRITERIA	WEIGHT	A SCORE	A WT. SCORE	B SCORE	B WT. SCORE
A) Condition	10	5.7	57	7.1	71
B) Capacity	7.25	7	50.75	2.33	16.9
C) Age	5	5	25	5	25
D) Operational Efficiency	7.5	6.67	50.02	6.67	50.02
TOTAL	29.75		182.77		162.92
STANDARDIZED SCORE			6.14		5.48
RANK			1		2

CONDITION (PROBLEMS)

	Serious Defic. 10 pts.	Mid-Point 7 pts.	Overall Average Defic. 5 pts.	Mid-Point 3 pts.	Minimal Defic. 1 pt.
• Maintenance Problems					
• Component Failures					
• Poor Availability of Parts					
• Lightning or Surge Damages					
• Safety Problems (Imminent Damages)					
• Electrical Code Violations					
• Emergency Generator Problems					
• Problems Related to Quality of Insulation					

TOTAL POINTS ÷ 80 (MAXIMUM POINTS) X 10 = SCORE

ELECTRICAL (Continued)

CAPACITY

	Yes	No
	10 pts.	1 pt.
• Planned Addition(s) to Increase Load on Capacity		
• Planned Functional Changes to Increase Load		
• Planned Changes to Emergency Power Circuits to Carry Added Load		
• Inadequate of Number of Branch Circuits		
• Inadequate of Redundancy/Backup Systems		
• Inadequate of Number and Size of Feeders		

TOTAL POINTS ÷ 60 (MAXIMUM POINTS) X 10 = SCORE

AGE

0-10 year old system	1 point
11-20 year old system	4 points
21-30 year old system	8 points
> 30 year old system	10 points

OPERATIONAL EFFICIENCY

	Yes 10 pts.	No(1) 1 pt.
• Excessive Loss Due to Low Distribution Voltage		
• Co-Generation/Reduction Utility Costs As a Result of Project		
• Low Power Factor Penalty Correction By Project		

TOTAL POINTS ÷ 30 (MAXIMUM POINTS) X 10 = SCORE

ENVIRONMENTAL/PATIENT PRIVACY PROJECTS

A. Category Description: Environmental/Patient Privacy construction projects are planned to provide for the correction of identifiable deficiencies related to, but not inclusive of patient privacy, support systems, esablishment of a bed service, and the alteration of existing space to meet specified program requirements. Many of the projects in this category are accomplished through renovation as opposed to new construction.

B. Criteria Descriptions: The prioritization process for these projects consists of the review of three factors:

1. New Bed Capacity or Transfer of Current Beds: Renovated areas for these projects could be in previously non-bed designated areas of the VAMC. The addition of new beds or the transfer of beds from one area to the newly renovated area impact on the prioritization rank.

2. Degree of Compliance with Various Standards: Consistent with the Agency mission of providing the best possible care to veterans, VA health care facilities will ensure patients an environment that enhances their positive self-image. An essential part of such an evironment and one to which every VA patient has a right is privacy, especially bedroom, bathing, and toilet privacy. In this regard, the VA has developed a stringent set of standards pertaining to room configuration and size, bathing and toilet facilities. Depending on a VAMC's compliance with these standards a ranking will be made. Other standards such as those of the JCAH, NFPA and HHS construction standards are also assessed in determining relative importance.

3. Number of Beds Affected: Beds in an area to be renovated for patient privacy are subject to reductions. The net bed loss for patient privacy considerations is a determinant for prioritization. As such, the project that will loose the greatest amount of beds indicates that a more serious patient privacy deficiency exists. Also included under the Environmental category are projects where there will be new beds added to a facility (i.e., new bed sections/structures). The facility that will gain the most number of beds is deemed to be the higher priority project. As such, "net gains" and "net loses" cannot be compared as they represent two distinct approaches to ward problems at a facility.

C. Criteria Weights:

Criteria	WEIGHT
1. New Bed Capacity or Transfer of Current Beds	5
2. Degree of Compliance with various Standards	10
3. Number of Beds Affected	8

D. Data Sources:

1. VA Patient Privacy Handbook
2. Space and Functional Deficiency Identification System
3. H-08-9, Space Planning Criteria in VA Facilities
4. SERP/JCAH Reports

E. Scoring: (Attached)

ENVIRONMENTAL/PATIENT PRIVACY

	WEIGHT	A SCORE	A WTD. SCORE	B SCORE	B WTD. SCORE
A) New Bed Capacity or Transfer of Current Beds	5	1	5	1	5
B) Degree of Compliance with various Standards	10	1	10	1	10
C) Number of Beds Affected	8	1	8	10	80
TOTAL	23		23		95
STANDARDIZED SCORE			1.0		4.13
RANK			2		1

New Bed Capacity or Transfer of Current Beds	Yes	No
	10 points	1 points

Degree of Compliance with various Standards
(VA and JCAH)

	Total Non-Compliance 10 pts.	Mid-Point 7 pt.	Average Compliance 5 pt.	Mid-Point 3 pt.	Total Compliance 1 pt.
• Room Configuration and Size (Patient Privacy)					
• Bathing and Toilet Facilities					
• Nursing Stations					
• Ward Configuration and Size					
• Life Safety Code Compliance					
• Handicapped Access Code Compliance					

TOTAL POINTS ÷ 60 (MAXIMUM POINTS) X 10 = SCORE

ENVIRONMENTAL/PATIENT PRIVACY (Continued)

Number of Beds Affected - Projects in question will first be grouped into 1) those that will result in a net gain of beds (new bed capacity or transfer projects) and 2) those that will result in a net loss (patient privacy projects). These "like" grouping projects will then be scored according to the following methodology:

NET GAIN - The greater the number of beds to be gained for a particular project the higher the rank for that project.

NET LOSS - The greater the number of beds to be lost, the higher the rank for that project.

Under each classification (GAIN/LOSS) points will be assigned to the ranked projects by assigning 1 point to the lowest ranked one and 10 points to the highest. When comparing more than 2 projects the following tables will be used to assign points to the projects falling in a relative rank order between the highest and lowest rank projects.

	LOW RANK				INTERMEDIATE RANK				HIGH RANK
3 projects	1				5				10
4 projects	1		4				7		10
5 projects	1		2.5		5		7.5		10
6 projects	1	2		4		6		8	10

FIRE AND SAFETY

A. Category Description: The medical center develops a fire and safety project to correct either cited fire and safety deficiencies or potential deficiencies.

B. Criteria Descriptions:

1. Level of Risk: Fire and Safety deficiencies vary. Some are considered more of a threat to the patients and staff personnel than others. As a result, evaluations are made of the type of work required to correct various deficiencies and the ranking of these corrections in a priority order. For example, the installation of total sprinkler protection is given the highest "level of risk" priority. The evaluator reviews the Form 10-1193 (project submission) and the project's scope, as developed during the advance planning fund phase. From these sources is determined the two categories of corrective action in a project that are highest on the priority list. The evaluator adds the two selected priority numbers and the sum is the raw score for the level of risk. The next step is to normalize the raw scores. The highest raw score is assigned a normalized score value of ten, (High Score divided by itself and multiply by 10.) All other project raw scores below the highest are given a normalized score with a value related to this high score of ten. (See Section E "Scoring")

2. Impact on Facility: Evaluation for establishing a raw score in this criteria category requires a review of the project scope to determine what portion of the medical center facilities, particularly the patient building or buildings, are affected by the project. Again, the Form 10-1193 and the project scope are the source for this information. This review determines the areas affected by both the highest and the next highest weighted corrective action as used above in the level of risk category. Again the priority weights are added to obtain a raw score and the new scores are normalized in the same manner as "Level of Risk":

3. Maximum Beds at Risk Per Building: Some medical centers have only one patient building while others are campus type with two or more patient buildings. Since the number of beds in the area or areas affected by the project vary, this criteria weights the number of beds at risk. Source of this data is the form 10-1193 and the Gains and Losses sheet. Scoring is based on the greater number of beds in the area of the project, the higher the score. The review, similar to the impact on facility category, determines the areas affected by both the highest and the next highest weighted corrective action as used in the level of risk category. The priority weights are added to obtain a raw score and the raw scores are normalized as in the other criteria categories.

C. Criteria Weights:

Criteria	Weight
1. Level of Risk	9.8
2. Impact on Facility	7.2
3. Maximum Beds at Risk	7.2

D. Data Sources:

1. Joint Commission on the Accreditation of Hospitals (JCAH)
2. Annual Inspection of the Regional Safety and Fire Protection Engineer (RSFPE)
3. Fire Safety Evaluation System (FSES) Studies

E. Scoring: (Attached)

FIRE & SAFETY

CRITERIA	WEIGHT	A SCORE	A WT. SCORE	B SCORE	B WT. SCORE	C SCORE	C WT. SCORE	D SCORE	D WT. SCORE
A) Level of Risk	9.8	8.3	81.3	8.3	81.3	10	98	9.4	92
B) Impact on Facility	7.2	5	36	10	72	10	72	10	72
C) Maximum Beds at Risk	7.2	10	72	3	21.6	7	50.4	7	50.4
TOTAL	24.2		189.3		174.9		220.4		214.4
STANDARDIZED SCORE			7.82		7.23		9.11		8.86
RANK			3		4		1		2

Level of Risk

1) Determine that portion of the scope of the project that falls highest in the order of hierarchy of F/S emphasis areas. (See Attached). 2) Determine portion that ranks next in importance on the hierarchy. (Note: tiebreaker will go to the 3rd hierarchial level of the next portion of the project). 3) The points assigned to the hierarchial grouping are additive. 4) Normalize by dividing each project score under this criteria by the highest score in the group of projects being evaluated and then multiply the answer by 10.

Impact on Facility

Refer to chart to determine extent to which each portion chosen under "Level Of Risk" (1st and 2nd) affects the facility. Normalized scores are derived in the same manner as under "Level of Risk".

Maximum Beds At Risk

Refer to chart. Apply to buildings affected by the portions chosen under "Level of Risk". Normalized scores are derived in the same manner as under "Level of Risk".

LEVEL OF RISK

10 Install Total Sprinkler Protection
9 Vertical Protection
8 Corridor Wall Improvements/Upgrade Construction
7 Smoke Partitions/Horizontal Barriers
6 Sprinkler Hazardous Areas
5 Exit Improvements
4 Smoke Detection
3 Fire Alarm
2 HVAC Improvements/Smoke and Fire Dampers
1 Standpipes

IMPACT ON FACILITY

5 Affects More Than One Patient Building
4 Affects An Entire Patient Building
3 Affects More Than One Floor of Patient Building
2 Affects One Floor of One Patient Building
2 Affects Part of One Floor of Patient Building
1 Affects A Non-Patient Building

MAXIMUM BEDS AT RISK PER BUILDING

5 500 Beds Or More
4 250 to 499 Beds
3 101 to 249 Beds
2 26 to 100 Beds
1 25 or Less Beds

HEATING/VENTILATION AND AIR CONDITIONING

A. Category Description: Total or complete air conditioning continues to be authorized for all existing or new VA medical centers. Medical care considerations require environmental control in every patient care facility. This includes air conditioning systems that provide temperature control (heating and cooling), humidity control, filtration, air movement, ventilation and controlling the spread of infectious disease and smoke. Priority rankings are based largely on severity of envrionmental conditions among facilities. Exceptions to such priorities may be made to advance or delay an air conditioning project, to coincide with other large renovation or construction projects.

B. Criteria Descriptions: An HVAC Functional Effectiveness Matrix (FEM) has been developed (see attached section E) that provides specific information for identifying and ranking maintenance and major equipment replacement projects at VA medical facilities, by medical region and nationwide. This information is being used to select HVAC projects for funding, and can be broken down to specific functional areas such as nursing areas or service areas.

C. Criteria Weights:

Criteria	Weight
Functional Effectiveness Matrix	10

D. Data Source: HVAC Functional Effectiveness Matrix

E. Scoring: (Attached)

HEATING, VENTILATION, AIR CONDITIONING (HVAC)

CRITERIA	WEIGHT	A		B	
		SCORE	WT. SCORE	SCORE	WT. SCORE
Functional Effectiveness Matrix* (See Accompanying explanation)	10	5.92	59.2	5.85	58.5
STANDARDIZED SCORE			5.92		5.85
RANK			1		2

After determining the Functional Effectiveness Maxtrix (FEM), points, on a normalized scale of 1-10, will be assigned according to the following formula:

FEM ÷ 117 (MAXHIMUM FEM SCORE) X 10

FUNCTIONAL EFFECTIVENESS MATRIX

Effectiveness scores compared to VA Design Criteria.

- Cooling.
- Fresh Air.
- Filtration.
- Air Changes.
- Humidity Control.
- Smoke Control (fire).
- Pos/Neg Pressure.

Other Factors.

- Cooling degrees days.
- Age of system.
- Rating levels (0-3) are also weighted according to particular area in question, i.e., surgery, warehouse, etc.
- Square Footage

All of the above scores, factors and weights are processed by a computer to generate a score for each SFDI defined area at each VAMC.

LAUNDRY PROJECTS

A. Category Description: Laundry projects are planned when it is determined that they are the most cost effective way to insure that the quality and quantity of a medical centers daily linen needs are met.

B. Criteria Descriptions: In the prioritization of proposed renovations or replacements of a complete laundry or internal laundry system, the following criteria are applied:

1. Physical Condition: A medical center's existing laundry capability and future operational requirements are assessed. Such an assessment includes an evaluation of the existing as well as projected number of pounds of laundry to be processed; an examination of existing equipment and associated replacement dates; the age and condition of the exisitng laundry facility, the amount of money expended or projected to be spent on maintenance and repair of the existing laundry operation.

2. Functionality: These physical condition measures are taken into consideration in determining the functional effectiveness of the current plant set up to meet current and projected workload.

3. Number of VAMCs Affected: A final criteria is the extent of the subject laundry plant's impact on other VAMC's laundry needs in terms of the potential a consolidation of laundry operations may have on these other medical centers.

C. Criteria Weights:

Criteria	Weight
1. Functionality	10
2. Physical Condition	7
3. Number of VAMCs Affected	5

D. Data Sources:

1. SERP and JCAH Reports
2. Equipment Replacement Schedules

E. Scoring: (Attached)

LAUNDRY

		A		B	
	WEIGHT	SCORE	WTD. SCORE	SCORE	WTD. SCORE
A) Functionality	10	10	100	10	100
B) Physical Condition	7	10	70	7	49
C) Number of VAMCs Affected	5	4	20	6	30
TOTAL	22		190		179
STANDARDIZED SCORE			8.64		8.14
RANK			1		2

Functionality

• Accessibility of Transport Systems	Accessible 1 pt.	Mid-Point 3 pts.	Average Accessibility 5 pts.	Mid-Point 7 pts.	Not Accessible 10 pts.
• Optimal Flow of equipment/work in present location	Satisfactory 1 pt.	Mid-Point 3 pts.	Moderate Deficiency 5 pts.	Mid-Point 7 pts.	Un-Satisfactory 10 pts.
• Ability to handle projected capacity requirements	Satisfactory 1 pt.	Mid-Point 3 pts.	Moderate Deficiency 5 pts.	Mid-Point 7 pts.	Un-Satisfactory 10 pts.

TOTAL SCORE ÷ 30 (MAXIMUM POINTS) X 10 = SCORE

LAUNDRY (Continued)

Physical Condition

	Satisfactory 1 pt.	Mid-Point 3 pts.	Moderate Deficiency 5 pts.	Mid-Point 7 pts.	Un-Satisfactory 10 pts.
• Equipment Age/Condition					
• Structural Integrity of Building					
• Condition of Utilities					
• Level of Maintenance and Repair Costs					

	Total Compliance 1 pt.	Mid-Point 3 pts.	Moderate/Avg. Compliance 5 pts.	Mid-Point 7 pts.	Substantial Non-Compliance 10 pts.
• Life Safety Code Compliance					
	Yes 1 pt.	No 10 pts.			
• Presence of Air Conditioning					

TOTAL SCORE ÷ 60 MAXIMUM POINTS X 10 = SCORE

Number of VAMCs Affected

Score = Actual Number x 2 (if five or more are affected, this criteria would score 10 points).

NURSING HOME CARE

A. Category Description: Nursing Home Care is defined as the accommodation of convalescent or other patients who are not acutely ill, and not in need of hospital care. These individuals require skilled or intermediate nursing care, related medical services, individual adjustment services, therapeutic, recreational and spiritual activities; all of which are to be provided in a dignified and home like atmosphere. The Veterans Administration provides nursing home care to veterans with service-connected disabilities and, to the extent space is available, to veterans whose disabilities are not service-connected.

B. Criteria Descriptions:

1. Functionality: This criteria is subdivided into a study of (1) Adjacency of Support Services - The present NHCU's relation to Dietetics, Lab, Radiology, etc. (2) Staff Accessibility - Location of nursing station, nursing offices, and support services with regard to staff useability and the provision of medical services in the present NHCU, and (3) Nursing observability - Can all the rooms be observed from the nursing station and offices?

2. Physical Deficiencies: This criteria is subdivided into (1) Life/Safety Deficiencies - Safety deficiencies noted by JCAH and/or safety inspections. (2) Handicapped Access - Wheelchair ramps, wheelchair width doors, bathrooms, etc. (3) Patient Privacy - In the present NHCU are all rooms two-person rooms; do any large multi-bed (3+) rooms exist; what are the conditions of bathing and toilet facilities, (4) Other Plant Deficiencies - Electrical, HVAC, Elevator, etc.

3. District Unmet Need: This criteria assigns ranks to all districts according to the absolute change between current and projected beds and also assigns ranks to all districts according to percent of current unmet need with regard to current versus projected. Unmet need is for VA NHCU beds only. The need for VA beds is determined by MEDIPP which also determines the number of community and state beds which will be used to meet total veteran requirements.

In new presence NHCU's (where no NHCU beds exist, or where the new project does not impact on present NHCU beds), only the district unmet need criteria is used. Where the new NHCU project replaces or modernizes the present NHCU beds, all three criteria are used.

C. Criteria Weights:

Criteria	Weight
1. Functionality (Replacement/Renovation Only)	7.3
2. Physical Deficiency (Replacement/Renovation Only)	8.7
3. District Unmet Need	8.6

D. Data Sources:

1. Functionality: JCAH, SERP

2. Physical Deficiencies: FSES (Fire Safety Evaluation System, Studies), JCAH Surveys, Annual Inspection of the Regional Safety and Fire Protection Engineer
3. MEDIPP

E. Scoring: (Attached)

NURSING HOME CARE

CRITERIA	WEIGHT	A SCORE	A WT. SCORE	B SCORE	B WT. SCORE	C SCORE	C WT. SCORE
A) Functionality (Replacement/ Renovation Only)	7.3		N/A	4	29.2		N/A
B) Physical Deficiency (Replacement/ Renovation Only)	8.7		N/A	3.25	28.3		N/A
C) District Unmet Need	8.6	6.4	55.04	3.2	27.52	8.6	74.0
TOTAL			55.04		85.02		74.0
STANDARDIZED SCORE			6.4		3.46		8.6
RANK			2		1		1

NOTE: First step is to separate projects into "New Presence" and "Replacement/Renovation" projects. Each group will be ranked separately. "New Presence" is defined as a NHCU at a site where no beds were located before or where the new unit is not replacing any that may exist at the facility.

Functionality

	Acceptable 1 pt.	Mid-Point 3 pts.	On-Average Acceptable 5 pts.	Mid-Point 7 pts.	Not Acceptable 10 pts.
Adjacency of Support Services					
Staff Accessibility					
Nursing Observability					

TOTAL POINTS ÷ 30 (MAXIMUM POINTS) X 10 = SCORE

NURSING HOME CARE (Continued)

Physical Deficiencies

	Acceptable 1 pt.	Mid-Point 3 pts.	On-Average Acceptable 5 pts.	Mid-Point 7 pts.	Not Acceptable 10 pts.
Life Safety Compliance					
Handicapped Access Compliance					
Patient Privacy					
Other Plant Deficiencies (Electrical, HVAC, Elevator, Etc.)					

TOTAL POINTS ÷ 40 (MAXIMUM POINTS) X 10 = SCORE

District Unmet Need

1) Assign ranks to all Districts within a specified planning year, according to the absolute change between current and projected beds. Higher # is given higher priority. 2) assign ranks to all Districts according to % current unmet need with regard to current vs. projected. Higher % given higher priority. 3) average of rank orders gives overall ranking 4) Points for overall rank assigned as follows:

Rank	Pts.
1	28
2	27
3	26
"	"
"	"
"	"
28	1

Normalize to a scale of 1-10 (Points ÷ 28 X 10)

When two medical centers in the same district are being considered, the medical center with the highest priority as determined by the medical district is scored first and then the unmet need is recalculated for scoring the second medical center. The continued use of the medical district priority for the selection of the first medical center scored will be considered in the future.

OUTPATIENT IMPROVEMENT PROJECTS

A. Category Description: Outpatient improvement projects are planned to provide the space and functional relationships necessary to provide prompt and efficient service to patients requiring outpatient care. As the veteran population ages there will be a greater need for outpatient care. Placing greater emphasis on treating patients on an outpatient basis reduces the need for the costly alternatives of inpatient treatment. Outpatient improvement projects are usually requested for the purpose of constructing additional space or renovating existing space to improve functionality and/or workflow patterns.

B. Criteria Descriptions:

1. Workload: An analysis is made of current outpatient visits and existing space assigned to outpatient functions against projected outpatient visits and projected space needs according to criteria standards. This analysis gives the percent space deficiency for future needs. The higher the score, the higher the ranking.

2. Functionality: Using the VA's Space and Functional Deficiency Identification (SFDI) System, the functional arrangement of an outpatient clinic is scored. The higher the score, the more deficient the functional layout and the higher the priority rank. Another factor under functionality is how close an outpatient clinic is to support services, i.e., laboratory, radiology, dental and related administrative functions. The more distant the adjacency, the higher the rank.

3. Physical Deficiencies: Areas evaluated under physical deficiencies include accessibility of an outpatient clinic by handicapped patients, deficiencies cited by JCAH or other auditing reports, age and condition of the building (including adequacy of the utility systems), compliance with life/safety codes, parking accessibility and the extent of major expansion or modernization during the past ten years. Each of these areas are assigned points based upon the degree of the deficiency. The points are than totalled to determine an overall physical deficiency score. The higher the score, the greater the deficiencies and higher the priority rank.

4. Professional Delivery Capability: The objective of this criteria is to measure the impact a construction project may have on the ability to attract and retain medical care professionals and the effect on the facility's affiliation status, if any. Those facilities where there is a positive correlation between these factors and its outpatient services are deemed to be of a higher priority.

C. Criteria Weights:

Criteria	Weight
1. Workload	9.6
2. Physical Deficiencies	9.4
3. Functionality	7.8
4. Professional Delivery Capability	4.5

2.

OUTPATIENT IMPROVEMENT PROJECTS (Continued)

D. Data Sources:

1. Workload: MEDIPP (Medical District Initiated Program Planning)

   - Summary of Medical Programs (Office of Management and Statistics)
   - H-08-9 (Office of Construction Handbook, Space Planning Criteria for VA Facilities).

2. Functionality:

   - SFDI (Space and Function Deficiency Identification System)
   - Site Visit Observations and Evaluations
   - Medical Center descriptions found in Five-Year Facility Plans and VA Form 10-1193 (Application for Health Care Facility Project)

3. Physical Deficiencies:

   - JCAH Surveys
   - SERP Surveys
   - FSES (Fire Safety Evaluation System Studies)
   - Annual Inspection of the Regional
   - Safety and Fire Protection Engineer
   - DM&S Engineering Service
   - Five Year Facility Plans

4. Professional Delivery Capability:

   - DM&S Affiliated Education Programs Service
   - DM&S Academic Affairs Service

E. Scoring: (Attached)

OUTPATIENT IMPROVEMENTS

Criteria	Weight	A Score	A Wt. Score	B Score	B Wt. Score
A) Workload	9.6	5.1	48.96	4.5	43.2
B) Physical Deficiencies	9.4	3.57	33.56	6.14	57.72
C) Functionality	7.8	5.14	40.09	4	31.2
D) Professional Delivery Capability	4.5	2	9	10	45
TOTAL	31.3		131.6		177.1
STANDARDIZED SCORE			4.2		5.66
RANK			2		1

Workload
1) Determine current outpatient visits and existing space assigned to outpatient functions.
2) Determine projected outpatient visits and projected space needs according to H-08-9 criteria.
3) Divide current total space by projected total space. Subtract resulting figure from 1.0 to determine % deficiency existing compared to future needs.
4) Score equals percent deficiency represented x 10.

OUTPATIENT IMPROVEMENTS (Continued)

Physical Deficiencies

	Subtantial Non-Compliance 10 pts.	Mid-Point 7 pts.	Moderate/ Avg. Compliance 5 pts.	Mid-Point 3 pts.	Overall Compliance 1 pt.
Life Safety Compliance					
Handicapped Access Code Compliance					

	Yes (1 pt.)	No (10 pts.)
Major Expansion/Modernization In Last 10 Years		
Age of Outpatient Areas Under 40 Years		

	No/Un-Acceptable 10 pts.	Mid-Point 7 pts.	On Average Acceptable 5 pts.	Mid-Point 3 pts.	Yes/ Acceptable 1 pt.
Parking Access					

	Serious Overall Defic. 10 pts.	Mid-Point 7 pts.	Overall Avg. Defic. 5 pts.	Mid-Point 3 pts.	Overall low Level Defic. 1 pt.
Other Plant Deficiencies (Electrical, HVAC, Plumbing, Gas, etc.)					

	All Program Areas Cited as Defic. 10 pts.	Mid-Point 7 pts.	Half of Programs Cited 5 pts.	Mid-Point 3 pts.	No Programs Cited 1 pt.
Cited by JCAH					

TOTAL POINTS ÷ 70 (MAXIMUM POINTS) X 10 = SCORE

OUTPATIENT IMPROVEMENTS (Continued)

Functionality

	All Related Areas Acceptable 1 pt.	Mid-Point 3 pts.	Half of Related Areas Acceptable 5 pts.	Mid-Point 7 pts.	All Related Areas Not Acceptable 10 points
Adjacency to Support Services					
Clinic Layout for Staff and Patients					

SFDI Functional Score	0-.99 1 Pt.	1.0-1.99 2 Pts.	2.0-2.99 3 Pts.	3.0-3.99 4 Pts.	4.0-5.0 5 Pts.

Dispersion of Clinics	1-2 Locations/Floors 1 Pt.	3-4 Locations/Floors 5 Pts.	5 Or More Locations/Floors 10 Pts.

TOTAL POINTS ÷ 35 (MAXIMUM POINTS) X 10 = SCORE

Professional Delivery Capability

Potential for Recruitment/Retention of Professionals	Undesirable 1 Pt.	Moderate 5 Pts.	Highly Desirable 10 Pts.
Medical School Affiliation (Using determination assigned by Academic Affairs (14))	None 1 Pt.	Nominal < > 2 Pts. 3 Pts.	Strong < > 4 Pts. 5 Pts.

TOTAL POINTS ÷ 15 (MAXIMUM POINTS) X 10 = SCORE

PARKING PROJECTS

A. Category Description: Parking construction projects are planned to address parking shortages at those medical centers which, due to site constraints, are unable to provide adequate surface parking for patients, visitors, and employees. Parking construction projects provide access for patients to come to the medical center for outpatient treatment. They also provide visitors, volunteers and employees parking facilities.

B. Criteria Descriptions: In order to prioritize a parking structure project, the following criteria are considered:

1. Parking Deficiencies: An analysis is made that compares the current spaces available to the projected future need.

2. Alternatives to On-Site Parking: Adjustments are made to take into consideration alternatives, including ride sharing and public transportation.

3. Functionality: The existing parking areas are also evaluated by assessing the ability of the existing parking to accomodate peak parking needs, the proximity to services, and the ability to accomodate parking for the handicapped.

4. Impact: The impact of a proposed future construction project on a medical center's existing parking needs as well as the additional parking which may be required upon activation of additional medical services, must also be taken into consideration.

C. Criteria Weights:

Criteria	Weight
1. Parking Space Deficiency	9
2. Alternatives to On-Site Parking	8
3. Functionality	7
4. Future Project Impacts	5

D. Data Sources:

1. Parking Analyses
2. MEDIPP Workloads
3. SERP/JCAH Surveys

E. Scoring: (Attached)

PARKING

	WEIGHT	A SCORE	A WTD. SCORE	B SCORE	B WTD. SCORE
A) Parking Space Deficiency	9	5.2	46.8	6.6	59.4
B) Alternatives to On-Site Parking	8	10	80	7	56
C) Functionality	7	6	42	6	42
D) Future Project Impacts	5	10	50	5	25
TOTAL	29		218.8		182.4
STANDARDIZED SCORE			7.54		6.29
RANK			1		2

Parking Space Deficiency

Based upon workload, determine

$$1.0 - \frac{\text{Present Number of Parking Spaces}}{\text{Future Need for Parking Spaces (\#)}} \times 10$$

Deficiency calculation = score

Alternatives to On-Site Parking

	Maximum Potential 1 pt.	Mid-Point 3 pts.	Modest Potential 5 pts.	Mid-Point 7 pts.	Low Potential 10 pts.
• Potential for High Degree of Participation in Ride Sharing					
• Well-developed/Accessible Public Transportation to VAMC					
• Leased Space Potential					

TOTAL SCORE ÷ 30 (MAXIMUM POINTS) x 10 - SCORE

PARKING (Continued)

Functionality

	Un-Satisfactory 10 pts.	Mid-Point 7 pts.	Minimally Satisfactory 5 pts.	Mid-Point 3 pts.	Satisfactory 1 pt.
• Current parking areas able to accommodate peak periods of need.					
• Proximity of current parking areas to services.					
• Adequacy to Accomodate Handicapped Parking Needs					

TOTAL POINTS ÷ 30 (MAXIMUM POINTS) X 10 = SCORE

Future Projects Impact on Current Parking Areas

	Yes 5	No 1 point
• Future Addition(s) to Increase Need for Spaces		
• Future projects will eliminate or decrease number of current spaces.		

TOTAL POINTS = SCORE

REPLACEMENT/MODERNIZATION
(INCLUDING NEW HOSPITALS)

A. Category Description: As VA facilities get older, they can develop critical space and functional deficiencies in terms of the delivery of modern health care that may require a multiple corrective approach involving either total replacement or major modernization. Changes in characteristics of the veteran population, including migration patterns, also can create the need for expansion or contraction of medical facilities to provide needed care. Those VA medical facilities determined to be most in need of construction, replacement or modernization share common characteristics: these facilities have space, functional and technical deficiencies; operating officials and program managers assess the facilities to be inadequate to meet health care delivery needs; substantial amounts of incremental construction have been identified to enable the facility to continue operation; and a long-range comprehensive facility plan does or will indicate that replacement or modernization is the solution to correcting the identified deficiencies. For these VA medical facilities, this comprehensive approach is determined to be more efficient and cost-effective than a recurring multiple project approach.

B. Criteria Descriptions: This category contains projects which, because of their broad scope, represent a combination of any number of other construction categories. For example, a typical replacement/modernization project may be comprised of Fire and Safety, Environmental, Clinical Improvement, Outpatient and Nursing Home Care components. The criteria definitions for the individual category components are presented under the specific category. The relative priority order of these diverse Replacement/Modernization projects is determined by developing the score for each component category and combining these scores into a composite weighted score.

For new VA medical centers proposed for areas where no VA hospital presence currently exists, the same methodology would be used, with the exception that only those criteria applicable to the key components of new construction would be considered. Criteria relevant only to existing medical centers (i.e., relating to space and functional deficiencies) would not be used. Only the "unmet need" criterion as included under the following categories would be utilized: Clinical Improvements (Workload); Outpatient (Workload); Nursing Home Care (Unmet Need); and Patient Care Environment (New Bed Capacity and Number of Beds). Consequently, projects which would propose to meet a greater portion of projected unmet need would be ranked higher in priority.

C. Criteria Weights: See Scoring Sheet for applicable category(ies) under a project.

D. Data Sources: Data sources for the component categories used in developing the component score are presented under the specific category.

E. Scoring: (Attached)

REPLACEMENT/MODERNIZATION

Step 1) Determine the major component categories encompassed by the project. It will also be necessary to determine an approximation as to what percentage of the overall project scope is contained under the specific component category.

This will be determined by the official project description compiled at the time of the "conceptuals" presentation (for projects already under APF development) or from the project description included as part of the most recently approved Five Year Facility Plan (for pre-APF projects). Percentage determination will only apply to program related components unless a technical component is demonstrably a unique and separate component. Percentages will be determined as a combination of square footage and/or dollars associated with the component in relation to the total scope of the project.

Step 2) For each component category, as applied to that portion of the project scope, apply the category prioritization methodology established for that category.

Step 3) The total weighted score under each component category will be multiplied by that percentage of the overall project scope as determined under Step 1. This will result in a "Percentage of Weighted Score" for that component category.

Step 4) The sum of the "Percentage of Weighted Scores" for all applicable component categories will result in a "Composite Weighted Score" for the individual Replacement/Modernization category projects.

Step 5) The sum of the standardized scores for each component equals the project standardized score. Each standardized score is determined by dividing the "Percentage Weighted Score" by the "Total Component Weight" for the particular Component Category.

Component Category	A					B				
	Percent	Component Weighted Score	Percentage of Weighted Score	Total Component Weight	Standardized Component Score	Percent	Component Score	Percentage of Weighted Score	Total Component Weight	Standardized Score
Outpatient	5	245.3	12.3	(31.3)	(.39)	10	252.7	25.3	(31.3)	(.81)
Fire and Safety	10	112.2	11.2	(24.2)	(.46)	10	112.2	11.2	(24.2)	(.46)
Clinical Improvement	10	292.0	29.2	(30.8)	(.95)	N/A				
Environmental	60	230.0	138.0	(23.0)	(6.00)	60	170.0	102.0	(23.0)	(4.43)
Nursing Home Care	15	178.4	26.8	(24.6)	(1.09)	20	154.7	30.9	(24.6)	(1.26)
TOTAL			217.5					169.4		
STANDARDIZED PROJECT SCORE					8.89					6.96

RESEARCH PROJECTS

A. Category Description: Research projects are planned to provide the space necessary to allow investigators to conduct research in an appropriate environment. In the past, research laboratories were established wherever space could be found within the medical center. This has resulted in fragmentation of the research programs. More recently, efforts have been made to consolidate all research functions either in existing buildings or in a separate research building. The consolidations result in the ability to share equipment as well as promoting communication between investigators. In addition, research laboratories are removed from patient care and administrative areas, thus providing space needed for the expansion of other services and functions. The prioritization process for research projects consists of the review of three areas:

B. Criteria Descriptions:

1. Physical Deficiencies: In addition to the age and condition of a facility, evaluations are made related to deficiencies which have either been cited or risk being cited by regulatory agencies. Standards established by the Joint Commission on Accreditation of Hospitals (JCAH), Occupational Safety and Health Administration (OSHA), Nuclear Regulatory Commission (NRC), American Association for Accreditation of Laboratory Animal Care (AAALAC) and any other possible code deficiencies are considered.

2. Space Deficiencies: An analysis is made of the percent deficiency with regard to current space in use versus needed space. This is accomplished by applying space criteria standards contained in the Office of Construction Space Planning Handbook, H-08-9, Space Planning Criteria for VA Facilities. To develop a priority rank for research projects requested by different VA medical centers, a comparison is made of the space deficiencies which exist. The more deficient a research program is in space, the higher the ranking.

3. Functionality: Using the VA's Space and Functional Deficiency Identification (SFDI) System, the functional arrangement is scored. Also measured are the interrelationships of the labs to one another and to clinical support services. The higher the score, the worse the functional layout and the higher priority rank.

4. Compatability with VAMC Long-Range Plans: Projects that will contribute to the achievement of the VAMC's long-range goals/mission (or conversely would have a negative impact if not accomplished) are deemed to be of a higher priority.

C. Criteria Weights:

Criteria	Weight
1. Physical Deficiencies	9.25
2. Space Needs	9.25
3. Functionality	7.25
4. Compatability of Research Program with VAMC Long Range Plans	5.5

RESEARCH PROJECTS (Continued)

D. Data Sources:

1. Physical Deficiencies:

- JCAH Surveys
- NRC Surveys
- AAALAC Surveys
- FSES (Fire Safety Evaluation System Studies)
- OSHA Surveys

2. Space Deficiencies:

- SFDI (Space and Function Deficiencies Identification System)
- H-08-9 (Office of Construction Handbook, Space Planning Criteria for VA Facilities)

3. Functionality:

- SFDI (Space and Function Deficiencies Identification System)
- Site Visit Observations and Evaluations

4. VAMC Long Range Plans:

- MEDIPP (Medical District Initiated Program Planning) and input and Recommendations from Central Office program officials.

E. Scoring: (Attached)

	CRITERIA	WEIGHT	A SCORE	A WT. SCORE	B SCORE	B WT. SCORE
A)	Physical Deficiencies	9.25	2.8	25.9	3.6	33.3
B)	Space Needs	9.25	2.8	25.9	.4	3.7
C)	Functionality	7.25	4.28	31.03	7.14	51.76
D)	Compatability of Research Program with VAMC Long Range Plans	5.5	1	5.5	1	5.5
	TOTAL	31.25		88.33		94.26
	STANDARDIZED SCORE			2.83		3.02
	RANK			2		1

PHYSICAL DEFICIENCIES

• Life Safety Compliance	Overall Compliance 1 pt.	Mid-Point 3 pts.	Moderate/ Avg. Compliance 5 pts.	Mid-Point 7 pts.	Subtantial Non-Compliance 10 pts.
• Cited by JCAH • Cited by AAALAC (for Animal Research)	Not Cited As Deficient 1 pt.		Conditionally Cited as Deficient 5 pt.		Research Areas Cited as Seriously Deficient 10 pt.
• Type Structure (A)	Brick/Concrete 1 point		Metal 5 points	Wood 10 points	
(B)	All Structures Permanent 1 pt.	Mid-Point 3 pts.	Half of Structures Permament 5 pts.	Mid-Point 7 pts.	All Structures Temporary 10 pts.

For projects with animal labs: TOTAL POINTS ÷ 50 (MAXIMUM POINTS) X 10 = SCORE

For projects without animal labs: TOTAL POINTS ÷ 40 (MAXIMUM POINTS) X 10 = SCORE

RESEARCH (CONTINUED)

Space Needs

1) Determine number of investigators projected for future and the amount of space needed per H-08-9 criteria.

2) Divide current total space by projected total space. Subtract resulting figure from 1.0 to determine percent deficiency existing compared to future needs.

3) Score equals percent deficiency represented X 10.

Functionality

Proximity to Clinical Services	> 50% Disperson 10 points	25 - 50% Disperson 5 points	< 25% Disperson 1 point
Inter-Research Relationships	> 6 locations/floors 10 points	3 - 5 locations/floors 5 points	1 - 2 locations/floors 1 point
SFDI Functional Score	0 - .99 - 1.0-1.99 1 point 2 points	2.0 - 2.99 - 3.0 - 3.99 3 points 4 points	4.0 - 5.0 5 points
Animal Research Facilities (if applicable)	> 4 locations/floors 10 points	3 - 4 locations/floors 5 points	1 - 2 locations/floors 1 point

Maximum Points 35 (for projects with ARF) - TOTAL POINTS ÷ 35 (MAXIMUM POINTS) X 10 = SCORE

Maximum Points 25 (for all other projects) - TOTAL POINTS ÷ 25 (MAXIMUM POINTS) X 10 SCORE

Compatability of Research Program with VAMC Long-Range Plans

Based upon MEDIPP and strategic long range plans of facility, will there be a siginificant impact upon the VAMCs research caused by new programs or expansion of existing ones. Ex. Will a planned expansion of rehabilitation services cause a concurrent emphasis to expand the facilities research effort? As determined by professional judgment, a deemed significant impact will receive 10 points under this methodology. No significant impact will receive 1 point. The important consideration is that if the particular project in question is not accomplished, will there be a detrimental impact in terms of research support with regard to the quality of the future planned program(s)?

SEISMIC

A. Category Description: This category includes construction projects that have the primary purpose of correcting seismic deficiencies. These deficiencies have been identified through on site seismic studies at the VA facilities. The evaluation determines the degree of conformity of the structures to current VA requirements and identifies specific buildings which are in need of seismic correction. Construction projects are developed to correct the deficiencies in existing building by strengthening the building structure and providing bracing for ceilings, light fixtures, equipment, gas storage, elevators, and mechanical and electrical systems as required.

B. Criteria Description:

1. AMAX: AMAX is a probabilistic value that is used for the structural analysis and design of VA buildings in seismic areas. AMAX is the estimated maximum horizontal ground acceleration (in percent of gravity) and probable risk determined by specific site evaluation studies at VA facilities. These site studies examine the site geology and historic frequency, magnitude and risk of earlier earthquakes.

2. Beds: In those instances where identical AMAX scores are indicated, the decision as to which is the "highest priority" project will be based upon the number of beds to be affected by the project. The project with the greater number of beds will receive the higher priority. If a second tie breaker is needed, the number of bed buildings affected will be determined. The project with the greater number of bed buildings will receive the higher priority.

C. Criteria Weights:

Criteria	Weight
AMAX Rating	10
*Tie Breaker (Beds)	

D. Data Sources:

1. AMAX: VA Seismic Deficiency Summary Sheets contain the AMAX factor for each medical center in a risk category and indicate the current status of structural seismic strengthening of specific buildings at the facility.

2. Beds: MEDIPP

E. Scoring: (Attached)

SEISMIC

CRITERIA	WEIGHT	A		B	
		SCORE	WT. SCORE	SCORE	WT. SCORE
AMAX Rating **	10	1.83	18.3	1.83	18.3
*Tie Breaker (Beds)		171		467	
STANDARDIZED SCORE			1.83		1.83
RANK		2		1	

After determining the AMAX score, points, on a normalized scale of 1-10, will be assigned according to the following formula:

AMAX SCORE -- .6 (MAXIMUM AMAX SCORE) X 10)

* In those instances where an identical AMAX score is indicated, the decision as to which is the "highest priority" projected will be made based upon the number of beds to be affected by the project. The project with the greater number of beds will receive the higher priority. If a second tie breaker is needed, the number of bed buildings affected will be determined. The project with the greater number of bed buildings will receive the highest priority.

WAREHOUSE

A. Category Description: Warehouse construction projects are planned to correct existing deficiencies as well as to meet the projected future requirements for warehouse space.

B. Criteria Descriptions:

1. Space Deficiency: Under this criteria, a determination must be made as to the currently existing space (leased or medical center - based) in relation to what current and/or projected space needs are indicated.

2. Functionality: The interrelationships of the existing warehousing operation to the medical center needs.

3. Physical Condition: The physical condition of the existing warehouse structure(s) is also evaluated as to its structural integrity, security, compliance with fire and safety code standards, and the ability to safeguard controlled substances.

C. Criteria Weights:

Criteria	Weight
1. Space Deficiencies:	
• Leased	10
• Current	10
• Projected	5
2. Functionality	7
3. Physical Condition	5

D. Data Sources:

1. SERP, JCAH Reports
2. H-08-9, Space Planning Criteria for VA Facilities

E. Scoring: (Attached)

WAREHOUSE

		WEIGHT	A SCORE	A WTD. SCORE	B SCORE	B WTD. SCORE
A) Space Deficiencies:	Leased	10	10	100	10	100
	Current	10	-	-	-	-
	Projected	5	-	-	-	-
B) Functionality		7	2.8	19.6	6.4	44.8
C) Physical Condition		5	2.8	14	4.6	23
TOTAL				133.6		167.8
STANDARDIZED SCORE				6.07		7.62
RANK				2		1

A) Space Deficiencies

a) First question to be answered is whether the facility is leasing all of their warehouse space? If answer is "Yes", skip sections b and c. If answer is "No" proceed to section b or c. Sections b and c refere to "owned" space and the evaluations as to whether there is a current space deficiency or a future projected deficiency. Only one section need be applicable, but there may be instances where both apply.

Yes
10 points

b) Current: $1.0 - \frac{\text{Current Space}}{\text{H-08-9 Required Space}}$ = Percent Deficiency

c) Projected: $1.0 - \frac{\text{Current Space}}{\text{Projected Space Requirements}}$ = Percent Deficiency

Score for each measure is percent deficiency X 10

d) If there is a combination of leased and owned space, that percentage of the total space falling under each type space will receive that appropriate percent figure as applied to the leased/owned score. (Ex. 60 percent warehouse space leased: 60 percent X 10 pts. = 6 pts.
40 percent on-site space. Percent deficiency against criteria = 42 percent (score of 4.2) 40 percent X 4.2 pts. = 1.68 pts. 6 + 1.68 = 7.68 Space Deficiecny Score.

WAREHOUSE (Continued)

B) Functionality

	No Defic./ Accessible 1 pt.	Mid-Point 3 pts.	Moderately Deficient 5 pts.	Mid-Point 7 pts.	Seriously Defics/ Not Accessible 10 pts.
• Location/proximity to supply systems					
• Functional arrangements - separation of high pilfreage items (drugs, food, office supplies)					
• Accessibility to Incoming Trucks					

• Dock Protection (from elements)	Yes 1 point	No 10 points
• Presence of Dock Levelers	Yes 1 point	No 10 points

TOTAL POINTS ÷ 50 (MAXIMUM POINTS) X 10 = SCORE

C) Physical Condition (Degree)

	Satisfactory 1 pt.	Mid-Point 3 pts.	Moderately Deficient 5 pts.	Mid-Point 7 pts.	Unsatisfactory 10 pts.
• Structural Integrity (free from leaks, rotting, exposure to elements)					
• Security (Entrance and Intrusion Alarms)	Yes 1 point		No 10 points		
• Ceiling Height (≥/1 foot between sprinkler and top of bins)	Yes 1 point		No 10 points		
• Air Conditioning	Yes 1 point		No 10 points		
• Narcotics Safe Meets Criteria	Yes 1 point		No 10 points		

TOTAL POINTS ÷ 50 (MAXIMUM POINTS) X 10 = SCORE

Appendix B

Integrating The Projects Into A Single Priority List

1. After projects are scored in each major construction category and the weighted scores totaled as described in the previous stage (Appendix A), integration of projects into a prioritized list is achieved in the following way:

   a. The first step of the integration stage of the methodology is to standardize each project's score within its category on a 10 point scale. This is accomplished by dividing the sum of the criteria weights for each category into the sum of the weighted scores for each project in the category (Attachment B-1).

   A variation of the standardization procedure is applied to Hospital Replacement/Modernization projects, and other projects that are, in effect, a combination of several categories within a single project. Since Hospital Replacement and other combination projects are made up of several component parts (e.g., clinical improvement, nursing home, fire and safety), each component is first scored according to the criteria developed specifically for the category that it represents and standardized in the usual way. Following standardization of the score for each component, the percentage of the total project that each component represents is determined. Then the percentages are multiplied by the standardized scores and the result summed for an overall standardized composite score (Attachment B-2).

   b. Each project's standardized score is then increased by a programmatic weight assigned to that construction category. Thus, policy considerations are factored into the methodology through the use of programmatic emphasis weights. For example, a standardized score of 10 that had a programmatic weight of 85% increase would result in a final score of 18.5 (10 X 1.85). For those projects that consist of more than one construction category (e.g., nursing home, parking) an emphasis weight is given according to the construction category that represents the greatest proportion of the total project. The programmatic weights for the construction categories are presented in Attachment B-3 to this Appendix.

The programmatic emphasis weights were developed by a high-level panel representing a cross-section of VA Central Office (both Departmental and Agency levels) as well as the field (including regional directors, medical center directors and a hospital chief of staff). Panel members were selected on the basis of their broad overview of VA medical programs and the role of construction in supporting those programs. The programmatic weights reflect the panel's consensus which was reached after extensive discussion of the need for balance and emphasis in VA's medical care system and the construction program.

A similar executive level group will meet annually to review the extent to which current policy and system requirements are reflected in the major construction program. As necessary their deliberations will result in revisions of the programmatic emphasis weights or other factors in the priority setting methodology. The panel who participated in setting the initial programmatic emphasis weights are listed in Attachment 4 to the Executive Summary of this report.

c. The final step is to rank order all projects according to their final scores from highest to lowest (Attachment B-4). The result is a final prioritized list which reflects objective measures of facility deficiency or program need, as well as current policy considerations.

Atachment B-1

STEP 1: STANDARDIZE SCORES WITHIN EACH PROJECT CATEGORY

PROJECT #1 CLINICAL IMPROVEMENT (EXAMPLE) *

CRITERIA	WT.		Project Score		Weighted Score
PROFESSIONAL DELIVERY CAPABILITY	3.8	x	7	=	26.6
WORKLOAD	9.4	x	9	=	84.6
FUNCTIONALITY	8.0	x	4	=	32
PHYSICAL DEFICIENCY	9.6	x	8.7	=	83.5
	30.8				226.7

STANDARDIZE:

$$\frac{\text{WEIGHTED SCORE}}{\text{CRITERIA WEIGHTS}}$$

$$\frac{226.7}{30.8} = 7.36 \text{ STANDARDIZED SCORE}$$

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* THESE CRITERIA AND WEIGHTS APPLY ONLY TO CLINICAL IMPROVEMENT PROJECTS. CRITERIA AND WEIGHTS VARY BY PROJECT CATEGORY.

STEP 1: (CONTINUED)

HOSPITAL REPLACEMENT/MODERNIZATION (EXAMPLE)

HOSPITAL A.

COMPONENT PARTS	CRITERIA WTS.	WT. SCORE	STAND. SCORE		% OF TOTAL PROJECT		
OUTPATIENT IMP.	31.3	245.3	7.84	X	.05	=	.39
F&S	24.2	112.2	4.64	X	.10	=	.46
CLINICAL IMP.	30.8	292	9.48	X	.10	=	.95
PATIENT ENVIRON.	23	230	10.00	X	.60	=	6.00
NHC	24.6	178.4	7.25	X	.15	=	1.09
							8.89

COMPOSITE STANDARDIZED SCORE = 8.89

HOSPITAL B.

COMPONENT PARTS	CRITERIA WTS.	WT. SCORE	STAND. SCORE		% OF TOTAL PROJECT		
OUTPATIENT IMP.	31.3	252.7	8.07	X	.10	=	.81
F&S	24.2	112.2	4.64	X	.10	=	.46
PATIENT ENVIRON	23	170	7.39	X	.60	=	5.43
NHC	24.6	154.7	6.29	X	.20	=	1.26
							6.96

COMPOSITE STANDARDIZED SCORE = 6.96

STEP 3: LIST PROJECTS FROM HIGHEST TO LOWEST

(SAMPLE)

CONSTRUCTION PRIORITY WEIGHTING, SCORING AND RANKING (DRAFT)

PROJECT RANK	FACILITY/ STATION	CONSTRCTN. CATEGORY	PRGMATIC GROUP	PROJECT STD.SCR.	PRGMATIC WEIGHT	FINAL SCORE
1	A	FIRE/SFTY.	SFTY/PH.PLT	9.11	1.90	17.31
2	B	FIRE/SFTY.	SFTY/PH.PLT	8.86	1.90	16.83
3	C	REPL/MOD.	REPL./MOD.	8.89	1.85	16.45
4	D	NHC	EXT. CARE	8.60	1.90	16.34
5	E	FIRE/SFTY.	SFTY/PH.PLT	7.82	1.90	14.86
6	F	LAUNDRY	NON-CL.SUPT	8.64	1.60	13.82
7	G	FIRE/SFTY.	SFTY/PH.PLT	7.23	1.90	13.74
8	H	CLIN.IMPRV.	INPT. HOSP.	7.36	1.85	13.62
9	I	LAUNDRY	NON-CL.SUPT	8.14	1.60	13.02
10	J	REPL/MOD.	REPL./MOD.	6.96	1.85	12.88
11	K	PARKING	NON-CL.SUPT	7.54	1.65	12.44
12	L	WAREHSE.	NON-CL.SUPT	7.62	1.60	12.19
13	M	ADMIN.	NON-CL.SUPT	8.11	1.50	12.17
14	N	NHC	EXT. CARE	6.40	1.90	12.16
15	O	CLIN.IMPRV.	INPT. HOSP.	6.54	1.85	12.10
16	P	CLIN.IMPRV.	INPT. HOSP.	6.48	1.85	11.99
17	Q	ADMIN.	NON-CL.SUPT	7.84	1.50	11.76
18	R	OPT.IMPRV.	AMB. CARE	5.66	1.90	10.75
19	S	ELECTRIC	SFTY/PH.PLT	6.14	1.75	10.75
20	T	PARKING	NON-CL.SUPT	6.29	1.65	10.38
21	K	BOILERS	SFTY/PH.PLT	6.05	1.70	10.29
22	U	HVAC	SFTY/PH.PLT	5.92	1.70	10.06
23	V	HVAC	SFTY/PH.PLT	5.85	1.70	9.94
24	W	WAREHSE.	NON-CL.SUPT	6.07	1.60	9.71
25	X	ELECTRIC	SFTY/PH.PLT	5.48	1.75	9.59
26	Y	DOM.	EXT. CARE	6.24	1.40	8.74
27	Z	DIETETICS	NON-CL.SUPT	4.99	1.70	8.48
28	AA	DOM.	EXT. CARE	5.83	1.40	8.16
29	AB	OPT.IMPRV.	AMB. CARE	4.20	1.90	7.98
30	G	DIETETICS	NON-CL.SUPT	4.44	1.70	7.55
31	AC	PT.PRVCY.	INPT.HOSP.	4.13	1.70	7.02
32	AD	NHC	EXT. CARE	3.46	1.90	6.57
33	AE	BOILERS	SFTY/PH.PLT	3.15	1.70	5.36
34	AF	RESEARCH	RSH/EDUC	3.02	1.65	4.98
35	U	RESEARCH	RSH/EDUC	2.82	1.65	4.65
36	I	SEISMIC	SFTY/PH.PLT	1.83	1.60	2.93
37	AG	SEISMIC	SFTY/PH.PLT	1.83	1.60	2.93
38	AH	PT.PRVCY.	INPT.HOSP.	1.00	1.70	1.70

Attachment B-3
IL 10-86-2
February 12,

STEP 2: APPLY PROGRAMMATIC EMPHASIS WEIGHTS

(EXAMPLE)

PROGRAMMATIC GROUP	CONSTRUCTION PROJECT CATEGORY	PROGRAMMATIC EMPHASIS WT. (% INCREASE)
HOSPITAL REPLACEMENT/MOD.	REPLACEMENT/MODERNIZATION	85
	NEW	75
EXTENDED CARE	NHC	90
	DOMICILIARY	40
AMBULATORY CARE	OUTPATIENT IMPROVEMENT	90
INPATIENT HOSPITAL	CLINICAL IMPROVEMENT	85
	PATIENT ENVIRONMENT	70
NON-CLINICAL SUPPORT	ADMINISTRATION	50
	DIETETICS	70
	LAUNDRY	60
	PARKING	65
	WAREHOUSE	60
SAFETY/PHYSICAL PLANT	FIRE AND SAFETY	90
	SEISMIC	60
	ELECTRICAL	75
	HVAC	70
	BOILER	70
RESEARCH/EDUCATION	RESEARCH	65
	EDUCATION	50

USING THE EXAMPLE OF A CLINICAL IMPROVEMENT PROJECT, PROGRAMMATIC EMPHASIS WEIGHT WOULD BE APPLIED AS FOLLOWS:

STANDARD SCORE (7.36) X PROGRAMMATIC EMPHASIS WT. (1.85) = FINAL SCORE (13.62)

Appendix C

Implementing The Methodology

1. The Facility Planning Service in the Facility Engineering, Planning and Construction Office of the Department of Medicine and Surgery will be responsible for developing procedures to guide the further implementation of this methodology. The basic components of these procedures already are being utilized and will be submitted to the Chief Medical Director for formal approval before the FY 1987 major construction budget submission. The methodology initially will be applied to the lists of major construction projects for which advance planning has been completed and which are submitted with the VA's annual budget requests. It will be adapted subsequently for application to additional lists of construction projects, as appropriate, to support the VA's requirements for systematic facility, budgetary and program planning.

2. Scoring Procedures and Documentation

Detailed scoring procedures have been designed to assure consistent scoring of projects (intergroup reliability). Criteria for selecting the individuals who will determine project scores will be specified to assure a balance of pertinent technical and programmatic, as well as Central Office and field perspectives. Records of the scores provided by all participants will be retained, as will appropriate documentation of the basis for necessary subjective judgments. Facility Planning will coordinate the process, assemble needed information for use by raters, calculate scores relevant to fully objective criteria where pertinent data is available in Facility Planning, conduct interviews with the individuals who determine scores, and compute final project scores based on criteria weights, standardization procedures, and the integration methodology.

3. Technical and Programmatic Review

Facility Planning will review project scores for technical and computational accuracy, and will initiate an analytical review from a programmatic or policy-level viewpoint to assure that the resulting priority lists effectively accomplish formally stated policy goals and the needed balance among types of projects. This review is intended to focus on goals and project categories rather than the placement of individual projects on the list. Any resulting changes in weights or criteria would be applied systematically and be fully documented.

4. Updating and Improving the System

Annually, Facility Planning will arrange for an executive review of the priority factors (e.g., programmatic weights or any other aspects which might have policy implications) to assure that priorities to be produced by the system will reflect current policies and assessments of DM&S broad program requirements. This review is expected to take place in January and February.

Facility Planning will also coordinate other refinements in the system which are made possible by new data or improved scoring procedures, or which are necessitated by new requirements. One potential refinement now being examined for feasibility is a suggestion that statutorily established construction factors be given additional weight in project scoring.

Veterans
Administration

Memorandum

Date: March 16, 1988

From: Associate Deputy Administrator for Logistics (005)

Subj: Status of the Proposed Medical Center Modernization Project, VA Medical Center Wilkes-Barre, PA (Project No. 693-026)

To: Honorable Paul E. Kanjorski

In follow-up to your request in the hearing this morning before the Subcommittee on Hospitals and Health Care, the status of the modernization project for VAMC Wilkes-Barre is as follows:

a. This project was approved for advance planning in FY 1985. The architect/engineer joint venture of Pyros & Sanderson/Vitetta Group has been hired to do the design and the preliminary drawings contract is scheduled for award in November 1988.

b. The project is currently scheduled for working drawing design/construction funding consideration in FY 1992.

c. The current tentative cost estimate of the project is $47.5 million; however, the actual cost estimate will not be known until the preliminary drawings are completed in the Fall of 1989.

d. The current scope of the project, which will be refined in more detail during the preliminary drawings, proposes to correct serious space and functional deficiencies in the admitting, outpatient and related clinical service area. Previously, this project did include bed ward renovations, but was removed due to phasing problems. The renovation project, tentatively scheduled for FY 1993, will address fire and safety and patient privacy deficiencies on the bed wards. As a separate project, it will facilitate the renovation of bed wards which currently contain clinical functions. These clinical functions will be consolidated into one building under the modernization project (693-026) thereby making room on the bed wards for the fire and safety and patient privacy corrections.

e. To date, Senate and House Veterans' Affairs Committee authorization has not been received for either of these projects. However, such authorization usually is not provided until the funding request is submitted, which, as noted is tentatively scheduled for FY 1992.

I hope this information is helpful. Should you or your staff have any further questions, please feel free to call me on 233-2192.

Susan

SUSAN LIVINGSTONE
Associate Deputy Administrator
for Logistics

STATEMENT OF THE HONORABLE MICHAEL BILIRAKIS
MEDICAL FACILITIES CONSTRUCTION PROPOSAL FOR FY89
MARCH 16, 1988

MR. CHAIRMAN, I WISH TO BRIEFLY COMMENT ON THE VETERANS ADMINISTRATION'S CONSTRUCTION REQUEST FOR FISCAL YEAR 1989.

QUITE FRANKLY THE BUDGET REQUEST IS INADEQUATE. THE FY89 BUDGET REQUEST FALLS $22 MILLION SHORT OF THIS YEAR'S FUNDING LEVEL. I FIND THIS QUITE DISTURBING CONSIDERING THE FACT THAT THE INCREASING VETERAN POPULATION WILL NO DOUBT NEED MEDICAL CARE. AT A TIME WHEN THE NUMBER OF INPATIENT TREATMENT HAS GROWN BY 24% AND THE NUMBER OF OUTPATIENT VISITS HAS GROWN BY 62%, I BELIEVE IT IS UTTERLY INCONCEIVABLE THAT THE VA SUGGEST SUCH DRASTIC CUTS IN THE MEDICAL BUDGET.

LAST WEEK THE FULL COMMITTEE RECOMMENDED THE FUNDING FOR CONSTRUCTION OF THREE NURSING HOMES IN ADDITION TO THE TAMPA NURSING HOME.

ON A POSITIVE NOTE, I WAS EXTREMELY PLEASED THAT THE VA INCLUDED A REQUEST FOR $6.7 MILLION FOR THE 120-BED NURSING HOME UNIT IN TAMPA, FLORIDA. AND I AM PLEASED THAT THE LEADERSHIP OF THIS FINE COMMITTEE HAS INCLUDED FUNDING FOR THE TAMPA NURSING HOME IN ITS BUDGET RECOMMENDATIONS.

AS I HAVE STATED QUITE OFTEN BEFORE THIS COMMITTEE, THE STATE OF FLORIDA, AND PARTICULARLY THE 9TH DISTRICT WHICH I AM HONORED TO REPRESENT, IS HOME TO A RAPIDLY ESCALATING ELDERLY POPULATION AND VETERAN POPULATION.

ALTHOUGH I AM CERTAIN THE VETERANS OF FLORIDA ARE DEEPLY APPRECIATIVE OF THIS FUNDING FOR THE TAMPA NURSING HOME, THERE IS STILL A GREAT NEED FOR A MUCH MORE AGGRESSIVE EXPANSION OF VA MEDICAL CARE AND FACILITIES IN FLORIDA.

AS THE AMERICAN LEGION CLEARLY INDICATES, THE LOWER RATIO OF COMMUNITY NURSING HOMES IN FLORIDA COMPARED TO OTHER STATES IS VERY APPARENT. FUNDING IS INADEQUATE.

THE PROPOSED REDUCTIONS IN FUNDING FOR THE VA CAUSE ME DEEP CONCERN AND I AM PARTICULARLY CONCERNED WITH THE SHORT-SIGHTED REDUCTIONS IN CONSTRUCTION OF MEDICAL FACILITIES. HOW CAN WE KEEP OUR COMMITMENT TO OUR NATION'S VETERANS IF WE DO NOT PROVIDE FUNDING FOR THE CONSTRUCTION OF VA MEDICAL FACILITIES. THE PROPOSED REDUCTION IN FUNDING POSES A GRAVE THREAT TO THIS NATION'S COMMITMENT TO OUR VETERANS.

THERE ARE A FEW SPECIFIC PROJECTS IN THE STATE OF FLORIDA WHICH I WOULD LIKE THE VA REPRESENTATIVES TO ADDRESS. FIRST, WHAT IS THE STATUS OF THE PROPOSED FACILITY IN PALM BEACH. IT IS MY UNDERSTANDING THAT THE SITE SELECTION HAS NOT YET BEEN DETERMINED.

SECONDLY, WHAT HAS HAPPENED TO THE PROPOSED CLINICAL ADDITION FOR A SPINAL CORD INJURY CENTER AT THE VA MEDICAL CENTER IN TAMPA AND THE PROPOSAL TO CONVERT DOMICILARY BEDS TO SCI BEDS AT BAY PINES? I AM TROUBLED THAT I HAVE BEEN TOLD FOR THE LAST SEVERAL YEARS THAT THIS PROJECT IS INDEED NECESSARY BUT NOT YET ADDRESSED. THE FY 1985-1989 FIVE YEAR MEDICAL FACILITY CONSTRUCTION NEEDS ASSESSMENT CLEARLY STATED THAT THIS NEW CONSTRUCTION WAS NECESSARY. THIS IS A TOP PRIORITY AND ONE THAT I URGE IMMEDIATE ACTION.

THANK YOU MR. CHAIRMAN.

Statement of

The American Legion

1608 K STREET, N. W.
WASHINGTON, D. C. 20006

by

SAMUEL J. WALSH, ASSISTANT DIRECTOR
NATIONAL LEGISLATIVE COMMISSION
THE AMERICAN LEGION

and

RODNEY S. KIRK, ASSISTANT DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION

before the

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

on

FY 1989 VA MEDICAL FACILITY CONSTRUCTION BUDGET PROPOSAL

March 16, 1988

STATEMENT OF RODNEY S. KIRK, ASSISTANT DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
MARCH 16, 1988

Mr. Chairman and Members of the Subcommittee:

The American Legion is pleased to appear before the Subcommittee today, and to have the opportunity to present its views on the present status as well as the future of the Veterans Administration Medical Construction Budget. May we say at the outset that our organization is an ardent supporter of the medical construction program, and that our support has been enhanced as a result of information obtained through site visits completed by American Legion Field Representatives at VA Medical Centers and Clinics. The site visit reports include detailed descriptions of the needs and problems of VAMC medical personnel who many times practice modern medicine on sick and disabled veterans under less than optimum conditions, in part due to outdated and inadequate physical resources.

The VA medical care system as we know it today, was developed in the late 1940's and early 1950's. The construction of hospitals at that time was recognized as an expansion of capability necessary to fulfill the obligation to the veterans of World War II. Subsequent to that, the nation has engaged in two additional wars in Korea and Vietnam, and the needs of this system have drastically changed. The system continues to fulfill its mission of providing medical care to veterans, and has in addition, become a focal point in the medical education of the entire country. The hospitals have been designated by the Congress as a valuable contingency resource for the Armed Forces in case of a future conflict.

The practice of modern medicine has changed both in its substance and in its method of provision. Today we have available services that were unknown when many of the VA hospitals were originally constructed, such as organ transplants, dialysis, and treatment of then unknown diseases. It was recognized by the Congress that it would be necessary to replace the original hospitals after a 25-30 year period. It was established that a minimum schedule of replacement would require 3 new hospitals a year.

While there has been adaptation and renovation of some of the hospitals in the system, it has not been of the magnitude required to keep the system current. Instead we hear constant complaints of deterioration of facilities and unmet needs of veterans and the health care professionals who treat them. For example, operating rooms now require the presence of sophisticated equipment such as systems to monitor and to take over functions of the heart and lungs during certain surgical procedures. Originally, there was no way to anticipate these or other requirements that demand operating room suites now to be twice their original size. Radiology suites were constructed without anticipating such equipment needs as CAT Scanners and Magnetic Resonance Imaging. It was unknown that procedures such as cardiac catherization would be carried out in the X-ray area. In addition, the method of offering medical care has changed from total in-house treatment to the increasing reliance on outpatient care, resulting in the need to increase outpatient areas in size by at least fourfold in some cases. These are but a few examples of the ongoing changes in the medical treatment arena that dictate the need for continuing construction in the VA health care system.

The FY 1989 budget request provides $367.8 million for major projects, $123.8 million for minor projects and $9 million for the parking garage revolving fund. This represents a bottom line decrease in VA's total construction program budget of almost $22 million from the previous year's level, down to $500.6 million.

At first glance, the $367.8 million for major projects might appear to indicate a substantial concentration within VA in terms of replacement and modernization efforts. However, of the $367.8 million, only $127.8 are earmarked toward this end, resulting in a mere four facilities receiving funds to bring their physical plants up to modern standards. Over 6% of the replacement and modernization funds ($8 million) are needed for the settlement of contractors' claims arising from the construction of a replacement hospital in Bronx, New York. To take this one step further, it is clearly evident that several areas of funding under major construction, although extremely important and urgently needed, do not relate to medical facility construction in the true sense. Almost 25% of the $367.8 million appropriated for the major construction projects' account will be absorbed through asbestos abatement, (almost $50 million); hazardous waste abatement, ($5 million); Calverton National Cemetery, ($12.5 million); Washington State sales tax, ($2.6 million); and Bronx contractor claims, ($8 million).

Among the major medical construction projects for which funding has been requested is a medical center modernization project at Newington, Connecticut; a replacement medical center at Pittsburgh, Pennsylvania (Aspinwall Division); clinical improvements and a Mental Health and Behavioral Sciences Center at the Indianapolis, Indiana VA medical center; a clinical addition and parking garage at the Atlanta, Georgia VA medical center; and a 600-bed replacement domiciliary at the Mountain Home, Tennessee VA medical center.

Other significant major construction proposals include a 120-bed nursing home care unit addition at the Tampa, Florida VA medical center and clinical improvement projects at the following medical centers: Beckley, West Virginia; Nashville, Tennessee; Perry Point, Maryland; and a new 30-bed spinal cord injury unit at the San Antonio, Texas medical center. Major renovations and fire and safety improvements are proposed for VA medical centers at Montrose, New York and Leavenworth, Kansas. Funding for the relocation of the Montgomery, Alabama Regional Office to agency owned grounds is also proposed.

The American Legion supports all of the above mentioned construction projects and we also realize there are many more projects urgently needed throughout the Veterans Administration system. As this Subcommittee is well aware, over half of all VA beds are in facilities which are over 30 years old.

Therefore, The American Legion was certainly pleased to see that the Veterans Affairs Committee recommended to the Budget Committee the addition of $15 million to the budget for design funds for the clinical addition and spinal cord injury center at the Dallas VAMC. The extreme need for these very same projects was expressed in the report issued following the site visit by an American Legion Field Representative to the Dallas facility, March 2-6, 1987. In the conclusion of the report, The American Legion presented a series of recommendations to VA Central Office for the purpose of addressing and correcting problems observed by the Field Representative during the course of the survey. Recommendation No. 1 was as follows: "That VACO approve and fund the major construction project, Clinical Addition/Renovate Building 2 and 60-Bed Spinal Cord Injury Center, without further delay." We strongly support the Committee's recommendation.

The fact is that many of the VA medical care system's physical plants have been allowed to deteriorate. The end result is that the system today has some of the finest and most up-to-date facilities in the country, and at the same time is using some extremely outdated facilities. These outdated facilities have serious functional and space deficiencies, fire and safety concerns, patient privacy shortcomings, inadequate mechanical and electrical systems, life safety code violations, and a host of other inadequacies that must be immediately addressed.

Take for example, the proposal in the FY 1989 budget that requests funding to construct a new five-story building at VAMC Mountain Home, Tennessee. This structure will allow VA to discontinue utilizing the existing buildings that house the 550-bed domiciliary program, which were constructed between 1903 and 1906. These buildings are of wooden beam construction, and have never been significantly renovated since they were constructed. Numerous fire and safety code deficiencies exist, in concert with several other life safety code deficiencies.

Another major project proposal in this budget will renovate Building 122 on the campus of VAMC Leavenworth, Kansas. Building 122 was constructed in the early 1930's and has had no major renovations since that time. Patient safety and privacy concerns are paramount within this building due to fire and safety deficiencies and inadequate space.

Mr. Chairman, we reiterate the fact that The American Legion certainly understands that all VA facilities cannot, are not and will not be newly constructed buildings. For the most part, the majority of the proposed construction budget funds for this year, as in the past, will be utilized to renovate and upgrade extremely old facilities, bringing them up to modern standards. The American Legion does feel very strongly however, that VA medical centers should have ample space and be provided with the necessary modern equipment. We expect, and we feel certain this Subcommittee would also, the existance of hospital environments that do not jeopardize the safety and well being of veteran-patients, and environments that are conducive to practicing modern day medicine. Anything less is not acceptable.

Mr. Chairman, as we have said in the past, the physical plant of the Department of Medicine and Surgery is a multi-billion dollar capital investment of the Federal Government. Allowing the system to deteriorate makes no sense at all and, in fact, contradicts the Administration's position on national defense when one considers that VA medical centers constitute the principal contingency resource to treat returning casualties during a national wartime emergency.

We must again express our concern that the VA must expand its independent nursing home care unit construction. The proposed 120-bed nursing home addition at the Tampa, Florida VA Medical Center, while badly needed, will not appreciably address the demand for this level of care in that State. New VA nursing home care unit activations, through new construction and by conversion of underutilized hospital bed space, in conjunction with state home programs when available, will all be required to provide long-term care to increasing numbers of eligible aging veterans. It should be noted that there is currently a lower ratio of community nursing home beds to population in the State of Florida relative to other states, and approvals for construction of new community nursing homes by the state have been limited. Furthermore, the Medical District in which Tampa is situated does not currently have a state extended care facility.

In 1984, VA published a report titled Caring For The Older Veteran, which was to be "a starting point and a framework for dialogue between the veteran constituency, policymakers and other community interests on how best to meet the needs of the total veteran population as that population ages." As clearly indicated in the report, demographics underscore the impending problems concerning aging veterans. The report states that by the year 2000, the VA's program of institutional extended care, which involves VA, state, and community resources, will need to care for 95,000-125,000 veterans each day, compared to 40,000 in 1985. Therefore, it is obvious that demographics prove the problem to be real and forthcoming. Persons on all sides of the coming debate agree on the dimensions of the problem. We addressed this in our analysis of the report Caring For The Older Veteran, as follows:

"Meeting the needs of the increasing number of aging veterans is the most serious challenge ever presented to the VA system. The challenge demands urgent and continued decisions, followed by implementation. The overall welfare of elderly veterans in the near and distant future relies completely on actions that must be accomplished now. The report analyzed in this document, however, does not outline any specific plan as to how or when VA will actually proceed. The report is excellent at identifying needs, as it was intended to do. What is needed next, and imminently, is a comprehensive plan, detailing how VA, Congress, and other key policymakers will provide the resources to meet what is, in fact, a tremendous challenge. There is no doubt that time is of the essence. When discussing VA health care availability to elderly veterans in the year 2000, the term paralysis by analysis cannot be allowed to become applicable. The American Legion is prepared to participate in the discussion of the issues we believe to be well identified in the subject report, and will take its share of responsibility for any plans to which it contributes."

In conclusion Mr. Chairman, The American Legion believes very strongly that it is important to maintain the capital plant of the VA medical care system, and that adequate funding must be provided to upgrade and replace existing facilities. You may be assured that The American Legion will continue to closely monitor ongoing renovation and replacement projects, and other construction, both major and minor, through reports by our Department Service Officers, and surveys by our Field Representatives. As is our present practice, we will continue to provide copies of our site visit reports to this Committee which contain information on the progress of ongoing construction, as well as construction needs that are identified at specific VA medical care facilities.

Once again, we thank the Subcommittee for the opportunity to present our views.

STATEMENT OF
DAVID W. GORMAN
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
FOR MEDICAL AFFAIRS
DISABLED AMERICAN VETERANS
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
OF THE
HOUSE COMMITTEE ON VETERANS AFFAIRS
March 16, 1988

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the over 1.1 million members of the Disabled American Veterans and its Ladies' Auxiliary, I would like to take this opportunity to thank you and the members of the Subcommittee for allowing us the opportunity to present our views on the Veterans Administration's medical construction program budget request for Fiscal Year 1989.

Before specifically addressing this issue, Mr. Chairman, we believe that it is important to place the Veterans Administration medical care program -- Department of Medicine and Surgery (DM&S) -- in its proper context to the delivery of health care to veterans.

The stated mission of DM&S is "to ensure that quality medical care is provided on a timely basis within the law to all authorized veterans."

This mission is formulated to provide:

* a complete medical and hospital service for the medical and hospital care of veterans;

* a program of education and training of health care personnel;

* a program of medical research; and

* health care services to members of the Armed Services during war or national emergency.

Medical Services

Mr. Chairman, as envisioned by the Administration's Fiscal Year 1989 budget request for the VA, the Agency's health care system will consist of 172 medical centers, 235 outpatient clinics, 126 nursing home units and 27 domiciliaries.

Within current statutory framework, the VA is authorized to furnish inpatient medical treatment to:

1. any veteran for a service-connected disability;

2. any veteran (for any disability) who has a service-connected disability rated at 50% or more;

3. any veteran who has a service-connected disability;

4. former prisoners-of-war;

5. World War I, Spanish American War and Mexican Border Period veterans;

6. Vietnam veterans exposed to certain herbicides, i.e., Agent Orange;

7. veterans exposed to ionizing radiation (atomic veterans);

8. any veteran whose discharge or release from active military service was for a disability incurred or aggravated in the line of duty;

9. any veteran for a nonservice-connected disability if unable to defray the costs of necessary treatment.

Contrary to the varied assertions voiced by a variety of individuals and sources, the VA medical care system has, is, and will continue to treat veterans who are, in the vast majority, service-connected and/or medically indigent. The fact is that not all veterans who are eligible for VA medical care choose to use the VA. Approximately 12.5% of the estimated 27.5 million living veterans have ever availed themselves of VA medical care.

Mr. Chairman, it seems abundantly clear, for a variety of reasons, that the VA is correct in its estimation that of the 13 million veterans eligible for VA medical care and treatment, only a portion will access into the system during their lifetime.

Clearly, fiscal constraints and finite federal dollars, in conjunction with established priorities and the freedom of choice of some veterans to receive medical care elsewhere, have dictated and will continue to dictate how many veterans enter the system.

The VA proposes to treat, on an inpatient basis, an estimated 1,083,933 veterans in Fiscal Year 1989, representing an increase of some 1,246 from Fiscal Year 1988. Approximately 31,195 veterans (an increase of 2,909) will be treated in VA nursing home care units while maintaining an average daily census of 12,681 (an increase of only 933) over 1988 levels. Additionally, 23,084,000 outpatient medical visits are estimated to occur in Fiscal Year 1989 (an increase of 211,000 from the Fiscal Year 1988 level).

Mr. Chairman, from Fiscal Year 1977 ($4.4 billion) to Fiscal Year 1988 ($10.1 billion), the VA health care budget has more than doubled in total actual dollars. However, once deflated to reflect movement in the Consumer Price Index, we view a virtually solid straight-line budget.

Additionally, a comparison of VA health care dollars as a percent of the total federal outlays for health, medicine and veterans hospital and medical care reveals a decline from 11.4% of total federal outlays in Fiscal Year 1977 to an estimated 8.4% in Fiscal Year 1987.

On average, VA patients are older, have lower incomes, have less health care insurance, and are often in need of specialized and more comprehensive type care than their counterparts in the general population. Also, VA inpatient services are intrinsically linked to outpatient services and specialized modalities of treatment.

The above, Mr. Chairman, illustrates, albeit briefly, the general scope, responsibility and workload encompassed in the VA medical care program. Suffice it to say, that the VA's Department of Medicine and Surgery is the nation's largest integrated, comprehensive, total medical care system in the country. It is the only system capable of providing a full array of health care services to this nation's eligible, disabled veterans.

Mr. Chairman, in our opinion, the delivery of quality health care to this nation's disabled veteran population entails a commitment to modern, safe and efficient medical care facilities.

To fulfill this commitment, it is necessary that the VA provide, on an continuing basis, for the reasonable expansion, renovation, modernization and replacement of its medical facilities.

To do less, Mr. Chairman, would, in our view, jeopardize and ultimately dismantle the VA health care system. Without active affiliations in programs of education, training and research efforts -- which serve as highly successful vehicles to attract quality health care providers -- the quality of care provided by the VA would not exist to the potential necessary to make the system viable.

The Congressional mandate that the VA act as the primary source of medical care back up to the Department of Defense would be, for all practical purposes, nullified absent medical construction funds to maintain the physical plant facilities of the VA's approximate 5,000 separate buildings.

Fiscal Year 1989 Construction Budget

As you know, Mr. Chairman, the VA's Fiscal Year 1989 program level request for construction is $500.6 million, some $22.1 million below the Fiscal Year 1988 level.

Of the total program level, approximately $413 million will be devoted to the VA health care system.

Highlights of the medical construction program include:

* $127.9 million for replacement and modernization projects;

* $40.4 million for general and miscellaneous projects to accomplish certain renovations, modifications, remodeling and other general improvements for support systems;

* $87.9 million for clinical improvements;

* $21.9 million for fire and safety improvements;

* $9.7 million for nursing home improvements;

* $1.5 million for outpatient improvements;

* $15.5 million for the design fund;

* $22.6 million for the advanced planning fund; and

* $32 million for the domiciliary program.

Mr. Chairman, a review of the VA's Fiscal Year 1989 construction request for medical programs reveals that the agency's ability to provide quality medical care in an appropriate setting is being placed in jeopardy.

Simply stated, while we support full funding of the proposed construction program, we are nevertheless concerned, not only with the quality of care currently being provided, but also about the VA's ability to meet the pressing demands being placed upon its health care system.

The DAV is concerned, as I know you are, Mr. Chairman, with how the VA will provide quality health care to the rapidly increasing aging veteran population.

According to VA statistics, there were three million veterans age 65 and older in 1980, constituting 10.5% of the total veteran population. By 1990, this figure is expected to rise to 7.2 million, representing 26.6% of the total population and by the year 2000, the number will reach nine million, translating to 37% of the veteran population.

We know that greater numbers of elderly veterans are seeking nursing home care from the VA, yet, of this medical construction budget, less than 2% ($9.7 million) is requested for nursing home care bed conversion, renovation and relocation.

Furthermore, while more and more elderly veterans are seeking nursing home care from the VA, this construction request reflects the Office of Management and Budget's (OMB) mandated policy which directs the VA to shift the responsibility for VA nursing home care to state and community nursing facilities. As a result, desperately needed new VA nursing home care projects and new bed construction are not forthcoming.

We support the VA's proposal to convert 289 hospital beds to nursing home care beds. However, as demand for nursing home care beds rapidly increases, we would urge the VA to direct greater attention to the conversion of beds already closed (or to be closed) to nursing home care beds. While the VA is considering the conversion of these few acute care beds within hospitals, we view their future plans to be directed more at a change of mission, i.e., conversions of entire hospitals.

Mr. Chairman, OMB and the VA continue to clearly circumvent the law (Section 5010(a)(1), Title 38, United States Code). In Fiscal Year 1989 the VA proposes to operate 3,088 fewer beds than that which is required by law.

The DAV has an inherent interest in the maintenance of VA hospital beds for the care and treatment of all eligible veterans. Yet, the Fiscal Year 1989 budget projects the loss of 913 hospital beds. This reduction will bring the total loss of hospital beds within the confines of the system to some 8,000 since 1982. Conversely, the VA has added only 4,400 nursing home care beds to the system over the same period, a net loss of 3,600 beds since 1982.

As you know, Mr. Chairman, the Medical District Initiated Program Planning (MEDIPP) is used as a plan to assess the system's future needs based upon a medical district prospective and the shift in veteran population.

Additionally, MEDIPP is capable of assisting in the construction program by integrating grass roots, programmatic planning; developing early conceptualization of facility construction needs; and by expanding the flexibility of space criteria to meet changes in mission requirements.

Mr. Chairman, the DAV supports the facility planning concept embodied in MEDIPP -- making the most cost-effective use of resources and funding that is available. The program should not only continue to provide input in the construction planning process but the involvement of individual medical center directors should be intensified during virtually all phases of the process.

The VA's Fiscal Year 1989 construction request includes $22.6 million for the Advanced Planning Fund (APF). As we understand it, the APF is designed to provide flexibility to explore various corrective strategies, propose alternative conceptual approaches and enable informed decisions to be made.

Additionally, the VA is requesting $15.5 million in Fiscal Year 1989 for the design fund. This fund, with certain restrictions, permits the VA to initiate working drawings for construction projects prior to final Congressional approval for funding. By using this process, the VA has estimated a significant time delay may be eliminated, thereby producing savings to the VA by the avoidance of additional inflationary cost.

Grants for Construction of State Extended Care Facilities

As you are aware, Mr. Chairman, this program provides grants to assist states to acquire or construct state home facilities for furnishing domiciliary or nursing home care to veterans and to expand, remodel, or alter existing buildings for furnishing domiciliary, nursing home or hospital care to veterans in state homes.

The VA's Fiscal Year 1989 appropriation request of $42 million will produce 732 nursing home and 22 docmiciliary beds.

Without question, Mr. Chairman, the domiciliary, nursing home and hospital care provided to this nation's veterans by state veterans homes has been invaluable in terms of offsetting the severe losses suffered by the VA's health care system as discussed earlier.

During Fiscal Year 1988, state veterans homes maintained an estimated average daily census of 8,936 nursing home, 4,331 domiciliary, and 515 hospital patients. In Fiscal Year 1989, state nursing homes' and domiciliaries average daily census is projected to increase by 925 and 34, respectively, while the average daily census in hospitals is projected to remain constant.

Recognizing the significant and important role of state veterans homes -- in terms of care provided to the rapidly aging veteran population and the cost effective use of federal taxpayer dollars that supplement this program -- we believe it is indeed wise to continue funding this program that ultimately produces savings to the government in terms of both construction and health care costs.

The DAV has always been supportive of the VA's medical construction program. However, the fact is that the capital plant of the VA health care system is deteriorating and will continue to do so at a rapid pace. One reason for this deterioration is, in our view, that the VA is attempting to play "catch up" with respect to renovations due to what could be classified as severe under funding over a long period of time.

Mr. Chairman, this budget request simply does not go far enough to allow the VA to accomplish what it must accomplish if the system -- which represents a multi-billion dollar investment on the part of the American taxpayer -- is to remain viable.

As you are well aware, Mr. Chairman, there has been considerable concern voiced over the VA's process of prioritizing major construction projects. As a result, via the 1985 appropriation process, the VA was directed to develop a new and meaningful prioritization process (which it has theoretically accomplished).

The DAV certainly supports this concept in theory. By establishing a methodology to prioritize and give emphasis to certain kinds of projects, i.e., nursing homes, clinical, fire/safety renovations, etc., which are felt to be of relative importance over other projects, the needs of veteran beneficiaries will, in our view, be best served. We would urge the VA to continue to refine and fine tune this process to ensure that such a list is, in fact, a prioritized one based on the real needs of veterans.

Mr. Chairman, one element imperative in the delivery of quality medical care is the adequacy of the medical facilities themselves.

We would encourage the Agency to move quickly toward the goal of establishing an appropriate design and approval process for its Medical Construction Program. This will be possible only when all interested parties are actively involved in the needs assessment and initial planning process.

There is an urgent need to streamline the process and eliminate any identified weaknesses and fragmentation while simultaneously forming a cohesive unit that will best serve the health care needs of the VA and, ultimately, disabled veterans.

Finally, Mr. Chairman, we would urge the Subcommittee's careful consideration of the recommendations and funding levels as contained in the Independent Budget for Veterans which has been provided to the Subcommittee. This budget document represents the cumulative and cooperative efforts of several major veteran's service organizations (AMVETS, DAV, PVA, and VFW) and represents, in our view, a realistic funding level that would allow the Agency to carry out a meaningful program of meeting the VA's overall construction needs.

Mr. Chairman, this concludes my testimony and, once again, I want to thank you for allowing us the opportunity to present our views on this most important issue.

STATEMENT OF

JAMES N. MAGILL, DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
WITH RESPECT TO

FISCAL YEAR '89 VETERANS ADMINISTRATION MEDICAL CONSTRUCTION PROPOSAL

WASHINGTON, D. C. MARCH 16, 1988

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

Mr. Chairman, thank you for the opportunity to present the views of the Veterans of Foreign Wars with respect to the Veterans Administration's medical facility construction program for Fiscal Year 1989. We are appreciative of this Subcommittee for holding this hearing and demonstrating its continuing concern for our nation's veterans.

As you know, the Veterans of Foreign Wars is proud to have joined AMVETS, Disabled American Veterans and Paralyzed Veterans of America in presenting to the Congress an independent budget for the Veterans Administration. Unlike last year, the FY '89 Independent Budget encompasses all Veterans Administration programs and, as the name implies, is independent of the Office of Management and Budget's (OMB) influence. This independent budget represents the minimum to which we believe the VA can effectively serve veterans. The VFW was asked to review the VA's construction program in order that the independent budget could suggest substantive recommendations for this Subcommittee to consider when deliberating the President's FY '89 proposal.

As in other VA programs, need forms the basis for determining the appropriate level of funding for construction. However, the VFW believes the VA does not have the information required to formulate a needs-based construction budget. In formulating a budget, an inventory basis should include the recognition of maintenance and repair needs of existing structures, systems and equipment used by medical centers; shortfalls in existing space, systems and equipment needed for the current activities of medical centers; and shortfalls in the space, systems and equipment that will be required by future medical center operations. The VA does not have an adequate inventory of construction needs, and the focus of the recently completed Capital Facilities Study is too narrow to serve as an inventory in this sense. Currently, the VA's construction priority-setting is limited to choosing among projects submitted by medical centers in the Five Year Facility Plan. These projects may or may not address the needs of the VA on the whole as the VA sees them on a priority basis. The current prioritization method simply places requested projects in priority order and does not address true priority need.

The absence of a sound basis for establishing construction priorities is but one of the major deficiencies in the VA construction process identified by careful studies the VA itself commissioned. These include excessive time required for projects--typically ten years from conception to completion; costs that are sometimes excessive; and, the inability to deal systematically with problems in the construction process.

In addressing the VA's construction needs, our most urgent concern is for the VA to develop a construction process that works well. We envision a process that completes projects more rapidly; chooses projects based on need and on a sound system for setting priorities; provides projects that adequately meet medical centers needs; is economical; and, catches problems quickly before they become severe through a system of standards and indicators for monitoring on-going performance along important dimensions such as quality, timeliness and cost.

An immediate task for the agency in meeting these goals is to develop a sound Facility Development Planning Process (FDPP). The successful completion of the pilot test program for the FDPP, involving four VA medical centers, is a prerequisite to implementing this new process system-wide. Once a proper Facility Development Planning Process has been established, the foundations necessary for developing a needs-based construction budget will be in place.

Because neither we nor the VA knows what construction needs are and what construction priorities should be, we are recommending very low total construction appropriations for FY 1989, appropriations totaling $541 million. This is close to $225 million, or almost 30 percent, below the record construction obligations of $766 million achieved in FY '87, and is only $18 million above the very tight appropriation total enacted for FY '88. Within this constrained total, we recommend a relatively large amount for minor construction in order to provide for the updating and repairing of VA facilities, most of which are now quite old.

We believe the true total of construction needs may be a good deal higher than the total appropriation of $541 million we are recommending. For example: the VA is contracting for only two replacement hospitals or top-to-bottom renovations of hospitals each year, which means it is on an absurdly long 86-year replacement cycle for its 172 hospitals. However, both the current federal budget deficit and the VA's lack of the basic information it needs for construction planning support our endorsement of the conservative appropriations.

With respect to specific funding levels, we believe a minimum of $368 million be appropriated for major construction in FY 1989, $35 million less than in FY '88, and almost $220 million less than was obligated in FY '87. We recommend this reduction in part because the VA lacks the information and processes to evaluate construction needs and in part because of general federal budget constraints. Once again, the VFW stresses this as a minimum recommendation. We note the House Veterans' Affairs Committee in its report to the House Budget Committee, recommends an additional funding for nursing homes. The VFW is appreciative of this action which recognizes the challenge facing the VA in caring for the aging population.

Within the $368 million total, we recommend $40 million for the advance planning fund and design fund. These funds permit projects to move continuously through the planning and design stages of the construction process rather than suffering lengthy interruptions while waiting for appropriations. As such, they deal with one of the major problems that has made VA projects take overly long to complete. The $40 million recommended for these funds substantially exceeds the amount allocated to them in past years. In funding them generously, we are suggesting an acceleration of the construction process. More importantly, we are ensuring a large dollar volume of projects "in the pipeline." Underfunding in this area leads to a choking off of projects by constricting the front-end planning and design stages. Our strategy of generous funding will permit a rapid expansion of the overall volume of major construction projects once VA priority-setting improves and the deficit declines.

With respect to minor construction, we recommend $169 million for FY 1989. The minor construction appropriation funds smaller projects, mostly ones devoted to keeping VA facilities in repair and up-to-date. Our recommendation of $169 million for this appropriation for FY 1989 is an increase of $53 million from the FY '88 level. We recommend this increase because of the importance of updating and repairing VA facilities. The largest number of VA facilities date from the 1950s, which means they are at an age when needs for updating and for repair and replacement are high. Moreover, the recommended $169 million for FY 1989 is actually slightly below the obligation level achieved in FY '87.

Most of the total minor construction appropriation--$10 million to be specific--should be spent on medical construction. Of these medical funds, we recommend that $20 million be set aside for conversion of medical center space to nursing home use, and be available only for this purpose. Modest amounts of the minor construction appropriation pay for construction projects in the VA's regional offices and its existing national cemeteries. Based on recent year' spending patterns, we estimate that $5 million and $10 million, respectively, are appropriate for these purposes. Finally, we recommend that $54 million of minor construction funds be spent for the VA staff that oversees the construction process. This consists primarily of the Office of Facilities, and we recommend continuation of the current staffing level.

This concludes my statement, and I will be happy to respond to any questions you may have. Thank you.

STATEMENT OF
FRANK R. DEGEORGE, ASSOCIATE LEGISLATIVE DIRECTOR
PARALYZED VETERANS OF AMERICA
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
OF THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
CONCERNING
VETERANS ADMINISTRATION MEDICAL FACILITIES CONSTRUCTION PROPOSAL FOR FISCAL YEAR 1989
MARCH 16, 1988

Mr. Chairman and Members of the Subcommittee, I am Frank R. DeGeorge, Associate Legislative Director, accompanied by Mr. Tom Davies, Associate Director of Architecture and Barrier Free Design. On behalf of PVA, we want to thank you for your invitation to appear here today. PVA appreciates the Subcommittee's scheduling of this hearing, and for the opportunity to express our views and concerns regarding this most important issue, the Veterans Administration Medical Facilities Construction Proposal for Fiscal Year 1989.

Our testimony today is congruent with the annual legislative priorities we recently presented and the concerns and recommendations in An Independent Budget by Veterans for Veterans' Programs. As you know, the "Independent Budget" was developed by four major Congressionally chartered veterans' service organizations (VSO's): American Veterans of World War II, Korea and Vietnam (AMVETS), the Disabled American Veterans (DAV), Veterans of Foreign Wars of the United States (VFW), and Paralyzed Veterans of America (PVA). The "Independent Budget," in the second year of publication, is also supported by the Blinded Veterans Association (BVA), Military Order of the Purple Heart (MOPH) and the following patrons:

American Association of Spinal Cord Injury Psychologists and Social Workers
American Association of Spinal Cord Injury Nurses
American Nurses Association
American Paraplegia Association
Association of American Medical Colleges
National Association of VA Physicians

We ask that this document be submitted for the written record and that all Committee Members refer to the construction portion of the "Independent Budget," which addresses our basic concerns with respect to the VA construction program. This morning PVA will elaborate on these concerns.

As in years past, in the absence of a comprehensive system for assessing total VA medical facility needs, it is difficult to comment on the adequacy of the construction budget request since no mechanism currently exists whereby total facility deficiencies can be quantified. The VA does not have the information required to formulate a needs-based construction budget. This is indeed an unfortunate and shameful situation that underscores the urgent need for the timely and proper implementation of the Core Process Recommendations identified in the Booz-Allen Hamilton/RTKL Comprehensive Study of the VA Construction Process. Properly implemented, these much needed procedural changes will allow decision-makers to measure the impact of the construction budget on the total VA facility need. At the present time there is no inventory of construction needs, and the focus of the recently completed Capital Facilities Study is too narrow to fulfill this role.

As we approach the three year anniversary of the BAH Study, there has been little significant progress in implementing its recommendations. Lack of progress is most apparent in the Facility Development Planning (FDP) program, whose funding was frozen by Congressional action because the VA has not shown the ability to appropriately carry out this initiative.

During the past two and one half years, the Office of Facilities has concentrated their efforts on internal reorganization rather than implementing critical procedural recommendations that will improve facility planning, design and construction services for the agency.

A clear understanding of the BAH Core Process Recommendations should have been a prerequisite to organizational realignment, followed by preparation of a realistic and detailed implementation plan with time schedules, milestones and priorities. However, the Office of Facilities has concentrated their efforts to-date on the FDP Program rather than simultaneously moving ahead with other Core Process Recommendations.

A facility planning database can, in fact, be developed simultaneously with the FDP Program. The database described in the BAH Study, which could assist your Committee in determining overall VA facility deficiencies, is not dependent on the completion of 172 FDP's. Gathering this data independently will both expedite the FDP process and reduce associated costs.

An important Core Process Recommendation which warrants immediate attention is that which addresses VA design standards and criteria, information which affects the planning data base and every proposed VA construction project. The 1985 Booz Allen and Hamilton Study was the second report in the past decade to cite major deficiencies in the design standards and criteria. An earlier report prepared by Shotwell-Anderson (October, 1978) identified similar problems and also contained specific guidelines and detailed recommendations which were never adopted. Maintenance of accurate criteria is fundamental in operating a national system of health care services, providing a basis for uniform levels of service, and establishing a formal mechanism for "corporate memory," learning from experience to prevent future mistakes.

In 1985, Booz-Allen and Hamilton, much like Shotwell-Anderson in 1978, identified the design criteria as 1) based on unreliable information which is not conveniently available; 2) obsolete in some areas; 3) based on incorrect assumptions regarding operating modalities, and 4) inflexible (see BAH II-7). In 1988, the PVA feels that the Office of Facilities has made little progress, with the exception of an SCI design guide, in this critical task. Inaccurate standards and criteria result in:

- a poor basis for measuring deficiencies and justifying projects
- poor guidance for the design of new facilities, resulting in higher design fees, project delays because of recycling, cost overruns, or construction of inadequate facilities
- inadequate information which makes architectural programming, another BAH core process recommendation, more difficult. Without clear standards and objectives, evaluation of completed projects (P.O.E.) is also less meaningful.

The Booz-Allen and Hamilton study recommended specific corrective actions for criteria and standards. To meet these objectives, PVA feels the Office of Facilities must commit more manpower and resources to this task through an interdisciplinary approach to coordinate facility programming, design and construction procedures. This approach should be supported by strong programs for Post Occupancy Evaluation, Research, and Value Engineering. PVA feels that "ad hoc" groups cannot fill this important role for information gathering and standards setting. As recommended in the BAH Study, the approach is similar to that used by the construction programs of the Army, Navy and Air Force.

The basic misunderstandings of the key elements of the BAH study represent a disturbing pattern of misguided efforts, including the Capital Facilities Study, the nursing home prototype and the use of questionable building systems, the subject of ongoing I.G. investigations. The narrow scope of the Capital Facilities Study has already been addressed. More than five years after the prototype nursing home care initiative began, it continues to fall far short of the goals envisioned by former VA Administrator Harry Walters.

While the demand for extended care services in the VA continues to grow, the lack of construction resources seriously undermines the VA's ability to provide much needed facilities to our aging veterans. We acknowledge the need to examine alternatives for nursing home care, but attempts to shift the burden of care to public and private health-care providers should be studied carefully, since they may be ill-equipped, unable or unwilling to accept this demand.

The recent study, commissioned by PVA, entitled "Veterans' Health Care: - Actions and Interactions," clearly indicates that reducing or eliminating current services will merely result in a "cost transfer," shifting the burden of cost to other public and private health providers, with no real savings. The VA has the primary responsibility for providing health care to the eligible veteran population. The patient care environment is important to medical program activities, and the planning and construction of VA facilities is an integral part of the VA mission to provide care to our nation's veterans.

The budget for VA construction is clearly inadequate as the Administration's proposal decreases funding for construction by $22.1 million for fiscal year 1989. However, PVA commends the House Veterans' Affairs Committee for its actions in restoring $15 million in funding during their markup on March 10, 1988, specifically for restoration of design funds for the clinical addition and spinal cord injury project at the Dallas VA Medical Center in Texas. We feel that the implementation of this project is long overdue and sufficient justification exists to include it in the FY 1989 budget request. PVA also appreciates your support for $8 million budgeted for a 30-bed Spinal Cord Injury Center at San Antonio, Texas.

The overall budget request for FY 1989 again fails to provide adequately for the expanding and changing health care needs of the aging veteran population. Specifically, we were gravely concerned with the Administration's proposal for only one additional VA nursing home, a net increase of only 120 beds, while the VA projects a shortage of 2,300 nursing home beds by the year 1992. The American Medical Association recently reported that the United States would have to build a 200-bed nursing home every day between now and the year 2000 to meet the needs for institutional long term care of our rapidly aging population.

PVA commends the full Committee for their recognition of this problem and their actions to restore $16.5 million for an additional 300 VA nursing home beds. However, as reported in the "Independent Budget," PVA believes that even more funding for nursing home beds is necessary. Specifically, we recommend $30 million for construction of four new VA nursing homes (480 beds).

In FY 1987, the VA converted only three beds in the entire system. Although the VA recently reported 15 additional conversions, the agency is still far short of their 1988 projection for conversion of 232 beds. With a $22 million budget reduction in construction and reductions in staffing levels, we suspect the 289 bed conversion proposed for FY 1989 will again fail to be realized.

In conclusion, without reliable statistical information on the VA medical facilities, we feel that there is no logical basis for resource allocation, nor are we confident that the facilities being constructed provide the best possible care for veterans at the most reasonable cost to the taxpayer. To provide Congress with reliable information upon which to fund the VA construction program, the Office of Facilities must move rapidly to implement the Booz Allen and Hamilton Study recommendations. Without proper oversight, we fear that the basic objectives of the BAH Study, like the VA study, "Caring for the Older Veteran," (July 1984), will be lost and their implementation will be delayed indefinitely.

Mr. Chairman, again, we commend you, the Subcommittee, and your staff for your continuing support and your efforts to ensure that an appropriate VA health care delivery system is provided for our nation's veterans. This concludes the testimony of PVA. We will be pleased to respond to any questions that the Subcommittee may have.

PVA
PARALYZED VETERANS
OF AMERICA
Chartered by the Congress
of the United States

SUBMITTED FOR THE WRITTEN RECORD

ADDENDUM

TO

STATEMENT OF

FRANK R. DEGEORGE, ASSOCIATE LEGISLATIVE DIRECTOR

PARALYZED VETERANS OF AMERICA

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

OF THE

HOUSE COMMITTEE ON VETERANS' AFFAIRS

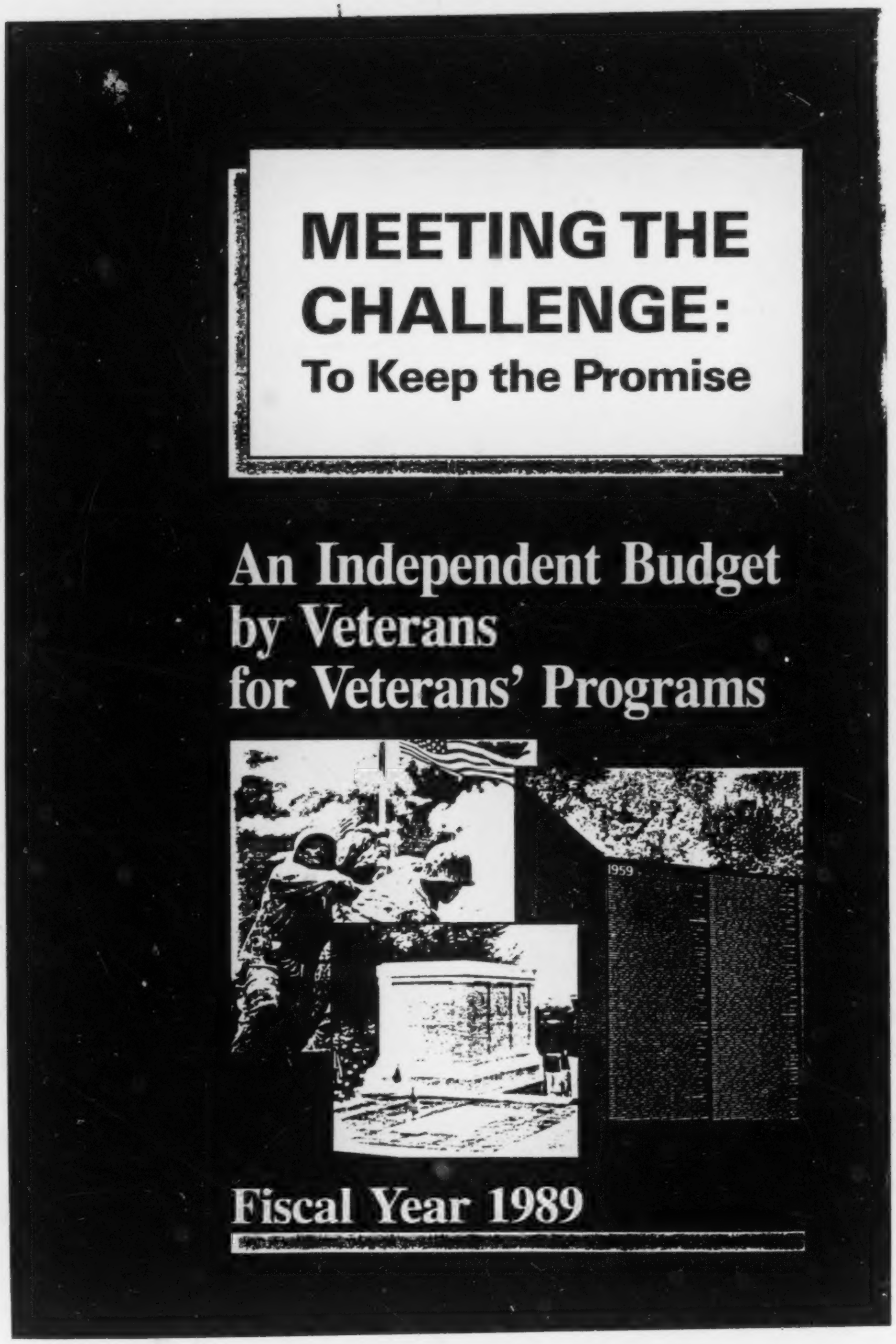
CONCERNING

VETERANS ADMINISTRATION MEDICAL FACILITIES CONSTRUCTION PROPOSAL

FOR FISCAL YEAR 1989

MARCH 16, 1988

801 Eighteenth Street, N.W., Washington, D.C. 20006 (202) USA-1300



MEETING THE CHALLENGE:
To Keep the Promise

An Independent Budget
by Veterans
for Veterans' Programs

Fiscal Year 1989

Prologue

This budget proposal is respectfully submitted to the Congress, which, over past years, has labored hard and long to provide an adequate budget for veterans' programs. This document, covering the main issues in the Veterans Administration's Annual Budget, is the product of a combined effort of four major Congressionally chartered veterans' service organizations. This unprecedented collaborative effort connotes a final loss of confidence in OMB's intention or ability to address veterans' issues objectively or to support the moral and legal obligations that this nation has accorded the men and women who have served our country.

James B King

James B. King
National Commander
American Veterans of World
War II, Korea and Vietnam

Gene Murphy

Gene A. Murphy
National Commander
Disabled American Veterans

John H. Michaels

John H. Michaels
National President
Paralyzed Veterans of America

Earl Stock Jr

Earl L. Stock, Jr.
Commander-in-Chief
Veterans of Foreign Wars
of the United States

Photographs courtesy of the National Park Service.

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CONSTRUCTION

THE CHALLENGE

As in other VA programs, need forms the basis for determining the appropriate level of funding for construction. However, in this, our first attempt to develop a VA construction budget, we quickly found that the VA itself does not have the information required to formulate a needs-based construction budget. Such a budget for health care projects would require as its basis an inventory of construction needs composed of:

- Maintenance and repair needs of existing structures, systems (electricity, heating, plumbing, etc.), and equipment used by medical centers;

- Shortfalls in existing space, systems, and equipment needed for the current activities of medical centers; and

- Shortfalls in the space, systems, and equipment that will be required by future medical center operations, as these future operations are envisaged in approved MEDIPP plans.

The VA does not have such an inventory of construction needs, and the focus of the recently completed Capital Facilities Study is too narrow to serve as an inventory in this sense. As a consequence, the VA's current construction priority-setting is limited to choosing among projects submitted by medical centers (in the Five Year Facility Plans). These projects may or may not address the needs that the VA as a whole sees as having highest priority, and there is no way of knowing what the full scope of need looks like. To put it bluntly, the VA does little more than pick its projects from 172 uncoordinated "laundry lists." The current prioritization methodology simply places requested projects in priority order and does not address true need.

The absence of a sound basis for establishing construction priorities is but one of the major deficiencies in the VA construction process identified by careful studies that the VA itself commissioned. Other major deficiencies include:

- Excessive time required for projects—typically 10 years from conception to completion for major construction;

- Costs that are sometimes excessive; and

- Inability to deal systematically with problems in the construction process.

Appendix B, "Problems in the VA's Construction Process," describes the major findings of the studies and provides more details of these challenges.

OUR STRATEGY

Our most urgent construction concern, then, is for the VA to develop a construction process that works well, specifically one that:

- Completes projects more rapidly. Five years from conception to completion of major projects is a good, if challenging, target;

- Chooses projects based on need and on a sound system for setting priorities;

- Provides projects that meet medical centers' needs well;

- Is economical; and

- Catches problems quickly, before they become severe, through an effective system of standards and indicators for monitoring on-going performance along important dimensions such as quality, timeliness, and cost.

An immediate task for the agency in meeting these goals is to develop a sound Facility Development Planning Process (FDPP). The successful completion of the pilot test program for the FDPP, involving four VA medical centers, is a prerequisite to implementing this new process system-wide. Upon successful completion of the pilot test, the Congress should then be willing to release the $10 million it has appropriated for Facility Development Plans, but frozen because the VA has not shown the ability to carry out appropriately this first step in fixing its construction process. Once a proper Facility Development Planning Process has been established, the foundations necessary for developing a needs-based construction budget will be in place.

Because neither we nor the VA knows what construction needs are and what construction priorities should be, we are recommending very low total construction appropriations for FY 1989, appropriations totalling $541 million, as shown in Table XVII. This is close to $225 million, or almost 30 percent, below the record construction obligations of $766 million achieved in FY 1987, and is only $18 million above the very tight appropriation total enacted for FY 1988. Within this constrained total, we recommend a relatively large amount for minor construction in order to provide for the updating and repairing of VA facilities, most of which are now quite old.

We believe the true total of construction needs may be a good deal higher than the total appropriation of $541 million we are recommending. For example, the VA is contracting for only two replacement hospitals or top-to-bottom renovations of hospitals each year, which means it is on an absurdly long 86-year replacement cycle for its 172 hospitals. However, both the current federal budget deficit and the VA's lack of the basic information it needs for construction planning support our endorsement of the conservative appropriations shown in Table XVII.

Our construction budget also reflects the re-establishment of a reasonable strategy for locating cemeteries in the National Cemetery System. At OMB's insistence, the VA has for years maintained that the system need have no more than one national cemetery with available burial space in each of the 10 federal regions. This means extremely long travel distances for widows and children of veterans honored by burial in a national cemetery. Realistically, it deprives many veterans of an option of burial in a national cemetery.

The VSO authors of this budget are unanimous in agreeing that a true National Cemetery System that offers veterans what it appears to promise must meet two criteria:

1. It must have a national cemetery with available grave space in every state. (Eight states do not now have open national cemeteries.)

2. There must be a national cemetery with available grave space within reasonable distance of the nation's major veteran population centers.

This budget starts the process of making the National Cemetery System meet these two criteria.

SPECIFIC RECOMMENDATIONS

Our specific recommendations for construction programs are, as in other program areas, based on our strategy for meeting the challenges in this program area.

Major Construction

We recommend $368 million be appropriated for major construction in FY 1989, $35 million less than in FY 1988, and almost $220 million less than was obligated in FY 1987. We recommend this reduction in part because the VA lacks the information and processes to evaluate construction needs and in part because of general federal budget constraints.

Within the $368 million total, we recommend **$40 million for the advance planning fund and design fund** as shown in Table XVII. These funds permit projects to move continuously through the planning and design stages of the construction process rather than suffering lengthy interruptions while waiting for appropriations. As such, they deal with one of the major problems that has made VA projects take overly long to complete. The $40 million recommended for these funds substantially exceeds the amount allocated to them in past years. In funding them generously, we are seeking to accelerate the construction process. More importantly, we are ensuring a large dollar volume of projects "in the pipeline." Under-funding in this area leads to a choking off of projects by constricting the front-end planning and design stages. Our strategy of generous funding will permit a rapid expansion of the overall volume of major construction projects once VA priority-setting improves and the deficit declines.

We have specifically designated **$30 million for construction of new VA nursing homes.** This amount will fund four nursing homes with 120 beds each. The aging of the veteran population requires this rate of addition of new VA nursing homes each year throughout the 1990s. (For a discussion of nursing home needs and our strategy for meeting them, see the chapter on the Medical Care appropriation, above.)

Finally, our recommendations for the major construction appropriation include **$3 million for the acquisition of land for a new national cemetery** in a state that currently has none. We recommend the addition of two new national cemeteries with available grave space each year until the National Cemetery System meets our two goals. We believe that one new cemetery each year can be obtained by donation from a state, and have budgeted for purchase of land for a second.

The remaining $295 million of the major construction appropriation should be devoted to other medical construction projects.

Minor Construction

We recommend $169 million for FY 1989. The minor construction appropriation funds smaller projects, mostly ones devoted to keeping VA facilities in repair and up-to-date. As shown in Table XVII, our recommendation of $169 million for this appropriation for FY 1989 is an increase of $53 million from the FY 1988 level. We recommend this increase because of the importance of updating and repairing VA facilities. The largest number of VA facilities date from the 1950s, which means they are at an age when needs for updating and for repair and replacement are high. Moreover, the recommended $169 million for FY 1989 is actually slightly below the obligation level achieved in FY 1987.

Most of the total minor construction appropriation — **$100 million** to be specific—should be spent on **medical construction.** Of these medical funds, we recommend that **$20 million be set aside for conversion of medical center space to nursing home use,** and be available only for this purpose. Our analysis of nursing home needs and how to meet them (see the chapter on the Medical Care appropriation) shows the need to convert approximately 1,000 VA hospital beds to nursing home use every year for the next several years. VA medical centers have been resistant to actually undertaking any conversions—including those that DM&S's own planning calls for. Setting aside $20 million a year for conversions will put an end to the claim that a lack of construction funds prevents conversion.

Modest amounts of the minor construction appropriation pay for construction projects in the VA's **regional offices** and its existing **national cemeteries.** Based on recent years' spending patterns, we estimate that **$5 million and $10 million, respectively,** are appropriate for these purposes. Finally, we recommend that **$54 million** of minor construction funds be spent **for the VA staff that oversees the construction process.** This consists primarily of the Office of Facilities, and we recommend continuation of the current staffing level.

Parking Garage Revolving Fund

We recommend $4 million for FY 1989. The Parking Garage Revolving Fund is a recently established appropriation. When the fund is fully on its feet, revenues from parking garages it has financed will pay for needed new parking facility projects, and no appropriations to the fund will be required. Currently, however, the fund is in a start-up mode and requires an appropriation because most projects it has financed are still under construction and not yet producing revenues. We recommend an appropriation of $4 million in FY 1989, the same as in FY 1988.

APPENDIX B

PROBLEMS IN THE VA'S CONSTRUCTION PROCESS

In developing this first Independent Budget for the VA construction program, we started from the VA's current construction program practices. The major studies the VA commissioned to examine its current construction process showed multiple, serious problems. As documented primarily in the "Comprehensive Study of the VA's Organization and Procedures for constructing Health Care Facilities" (completed for the VA by Booz, Allen & Hamilton and RTKL Associates in April 1985), these problems include:

- Excessive time is required to complete construction projects;

- The users of the construction projects—the individual VA medical centers—find the completed projects don't meet their needs well;

- The choice of projects is not based on a sound system for setting priorities, and there are other inefficiencies as well; and

- The VA only deals with problems in the construction process when they become glaringly obvious in particular projects. Even then, it does not make the systematic changes to the process necessary to prevent future recurrences of the problems.

EXCESSIVE TIME

The Booz, Allen/RTKL study found that the VA routinely exceeded its scheduled time for projects by 25-50 percent, and that its schedules were somewhat longer than those of other organizations carrying out similar construction. On average, the VA was taking over 10 years from initial project development to completed construction. The study attributed this slow pace to several problems. Two notable problems were that essential information needed to begin project design was difficult to obtain and there was a lack of accountability for timely progress in the planning stage of construction projects.

The excessive time required for VA construction makes it less likely that the needs identified at the beginning of a project will still be accurate reflections of medical center needs when the project is completed. This problem often leads to major project changes during design or construction phases, which cause still further delays.

USER DISSATISFACTION

A second major problem was dissatisfaction among VA medical centers with completed construction projects. According to the Booz, Allen/RTKL study, two factors appeared to cause this problem.

First, criteria for the amount and kind of space needed for various activities in VA medical centers were not sound. As a result, the users of the space often found it did not met their needs. Problems with the criteria include:

- Information needed for use of the criteria (principally staffing information) was often unreliable and difficult to obtain;

- Criteria in many cases appeared to be obsolete and based on assumptions that did not reflect the way health care and support services are actually provided; and

- Washington staff often insisted on applying the criteria inflexibly, with little respect for the reality of how services actually are delivered at the VA's medical centers.

Collectively, these problems underscored the need for changes in the way criteria are developed and maintained.

Second, VA medical center staff saw Central Office as unresponsive to their input during project design, and this resulted in time-consuming conflicts.

It seems desirable to develop procedures that more adequately accommodate users. However, some conflict between individual medical centers and Central Office may be inevitable: Each medical center focuses primarily on its own needs while Central Office is concerned with how to use a limited construction budget most effectively in meeting what it views as the highest priority needs of 172 medical centers. Also, it appears that considerable improvement in user satisfaction has occurred in response to changes put into effect since the Booz, Allen/RTKL report was completed.

UNSOUND PRIORITY SETTING AND INEFFICIENCIES

The Booz Allen/RTKL study found that neither individual VA medical centers nor the VA's Central Office had an inventory of construction needs. An inventory, it stated, should include three categories of information:

1. Maintenance and repair needs of existing structures, systems (electricity, heating, plumbing, etc.), and equipment used by medical centers;

2. Shortfalls in existing space, systems, and equipment needed for the current activities of medical centers; and

3. Shortfalls in the space, systems, and equipment that will be required by future medical center operations, as these future operations are envisaged in approved MEDIPP plans.

Without such an inventory, priority-setting is limited to a choice among projects that happen to be on lists submitted by medical centers (the Five-Year Facility Plans). These projects may or may not address the needs that the VA as a whole sees as having highest priority. The focus of the recently completed Capital Facilities Study is too narrow to serve as an inventory in the sense described above.

At individual medical centers, the report also found that, "poor coordination between current projects and future construction needs leads to design solutions that close off future options for development. In some cases, recent construction has even had to be replaced to meet new construction needs."

FAILURE TO ADDRESS PERFORMANCE PROBLEMS

"Problems in the VA construction process often reach major proportions before they are identified by top management and effective corrective actions are taken," according to the Booz, Allen/RTKL Study. "In many cases, even when significant problems exist, they come to the attention of top management only after they have been identified by outside organizations (e.g., OMB, GAO, Congress)."

"A lack of standards and indicators for measuring...." performance in the construction process appears to be the primary problem. "Because of the lack of standards, there is no information to evaluate...aspects of performance...." such as quality, timeliness, or cost, and VA top management "is forced to review detailed project-level information to monitor overall...performance" rather than having indicators it can track.

The report also found "a general perception in the VA that each construction project is unique and that the VA's health care facility construction process is completely different from...." health care facility construction outside the VA. As a result, indicators that are available and appropriate—such as cost per gross square foot for various types of construction—are not used. "The result is poor performance...." in important aspects of the construction process such as timeliness, cost, and quality.

The Associated General Contractors of America
Statement
House Committee on Veterans Affairs
Hospitals and Health Care Subcommittee
U.S. House of Representatives
Fiscal Year 1989 Appropriations
March 25, 1988

AGC is:

- More than 32,500 firms including 8,000 of America's leading general contracting firms responsible for the employment of 4,000,000-plus employees;
- 104 chapters nationwide;
- More than 80% of America's contract construction of commercial buildings, highways, industrial and municipal-utilities facilities

The Associated General Contractors of America has been a consistent advocate before Congress throughout this decade of the need to rebuild America's deteriorating infrastructure. AGC's research, along with that of other organizations, has identified a minimum annual capital investment need of approximately $43.1 billion for public buildings through the turn of the century. An area of particularly critical need and vital concern is the deteriorating condition of the nation's hospitals and other health care facilities, including those of the Veterans Administration.

The need for VA hospitals and health care facilities expands with the aging population of this nation's veterans. AGC has consistently supported an adequately funded construction program for Veterans Administration hospitals and health care facilities to ensure that the VA will meet its obligations to our nation's veterans. AGC again urges Congress to fund VA construction programs at levels sufficient to meet the needs of America's veterans.

America's veteran population is growing both in number and in age. Demographic statistics indicate the number of veterans over the age of 65 will increase from 5,750,000 in 1987, to 8,870,000 in the year 2000. To meet the needs of this aging population, the VA will have to increase nursing home capacity threefold in the next 20 years, from 40,000 beds to 120,000 beds.

Many Veterans Administration hospitals and health care facilities are badly in need of renovation or repair. A

Department of Health and Human Services survey conducted in the early 1980's concluded that $130 billion of construction was needed to replace obsolete health care facilities. Yet, the VA has been spending only 50% of the amount required annually to meet this need.

An American Hospital Association survey conducted in 1982 disclosed the deteriorating condition of both private and government operated hospitals in the U.S. The survey revealed that 21% of all U.S. hospitals reported that 50% or more of its inpatient facilities was over 30 years old. Federal hospitals reported a figure more than double that of all U.S. hospitals on this question. Nearly 47% of Federal hospitals reported that more than 50% of its inpatient facilities was more than 30 years old.

The VA's own surveys have demonstrated the need for significant expenditures in the VA's construction program to meet the growing health care needs of veterans. These needs include new construction as well as basic maintenance and repair of existing facilities.

The construction program recommended for FY 1989 by the Administration for the Veterans Administration is $367.8 million for major construction and $123.9 million for minor construction. Both funding levels are substantially below FY '88 levels. AGC believes the FY 1989 recommended funding levels are inadequate to address the serious infrastructure need for hospitals and health care facilities for veterans. AGC urges Congress to increase the funding of the VA's building program so that the agency can meet its obligations to the nation's veterans.

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSE

QUESTIONS OF THE HONORABLE G. V. (SONNY) MONTGOMERY
TO THE HONORABLE THOMAS K. TURNAGE
VETERANS ADMINISTRATION
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE HEARING
MARCH 16, 1988

QUESTION 1: In order for the Congress to assess the adequacy and appropriateness of the VA construction budget request, some measure of need is required. The VA's Capital Facility Plan would be very helpful as we look at the construction program for fiscal year 1989. When will the results of that recently completed survey be available to us since it was completed early this month?

RESPONSE: The information from the capital facilities studies has been received from the contractors and a preliminary analysis has been completed. Further analysis and preparation of a final report is now ongoing. It is expected that this report will be completed, reviewed and approved by the Administrator and available for the Committee in 60 days.

QUESTION 2: In a letter to me dated September 3, 1987, Dr. Gronvall stated that the VA Medical Center in Biloxi was exploring the relocation of the Mobile, Alabama Outpatient Clinic to a larger space. What is the status of that situation?

RESPONSE: We are currently in the early developmental stages of this action. Since Dr. Gronvall's letter of September 3rd, the Biloxi VAMC has updated their request to expand clinic space at Mobile based on the most recent projections of potential outpatient workload for the area. The Medical Center is now working on the necessary data package that will be used to physically size the clinic in accord with workload and staffing projections. Contact with the VAMC indicates they are nearing completion of this phase and anticipate forwarding the information to VA Central Office in the near future.

The next stage of the process involves calculating the space requirements and conducting the required studies to determine the most cost effective alternative (build or lease) to obtain the space needed. The outcome of this study, which is expected within six months, will determine the time necessary to complete the action.

QUESTION 3: Congressman James Traficant of Ohio has submitted testimony regarding the parking problem at the University Drive Division of the Pittsburgh VA Medical Center. What plans are there with regard to improving the parking situation. Can the Parking Revolving Fund be of use there?

RESPONSE: The VA's plan for improving the parking situation at the VAMC Pittsburgh is the construction of a parking facility. The VAMC has investigated this situation to identify interim solutions to alleviate the parking difficulties until the major project is constructed. Unfortunately, this investigation resulted in no viable interim solutions.

There are no funds available in the Parking Revolving Fund to construct this garage.

QUESTION 4: Please describe the status of the Parking Revolving Fund including the amounts obligated to date; the number of parking facilities that have used the Fund; and, projections for the Fund for fiscal year 1989.

RESPONSE: The parking revolving fund has received appropriations in the amount of $33,936,000 since the inception of this program. As of February 29, 1988, obligations of $13,147,000 and commitments (not obligated) of $20,339,000 have been made leaving an estimated balance of $450,000.

There are currently 13 medical centers that use the fund for leasing parking facilities. In addition, there have been construction awards at San Francisco, CA, and Baltimore, MD, as well as funding set aside for construction awards scheduled to be awarded in FY 1988 at Durham, NC, Syracuse, NY, and Huntington, WV.

In FY 1989 we anticipate that the fund will receive new appropriations of $9,000,000 for the Atlanta, GA, parking garage. In addition, parking receipts are estimated to be $629,000, and parking leases are estimated to be $402,000, resulting in a net increase of $227,000. This will bring the revolving fund uncommitted balance up to $677,000.

QUESTION 5: What other facility sharing agreements are being contemplated under the VA/DoD Sharing Law?

RESPONSE: VA and DoD contemplate negotiating sharing agreements in connection with these proposed construction projects:

- o Anchorage, Alaska - A complete renovation of USAF Hospital Elmendorf is planned with a projected FY 1992 start. Some 196 beds are envisioned for the Air Force and 18 additional beds for veterans. No additional medical services would be opened, but the current level of services would be expanded.

- o El Paso, Texas - The Army has allotted 70 existing beds to the VA at Beaumont Army Medical Center with a potential expansion to 105 beds. Selected VA clinical staff are available to treat both veterans and Army patients. The VA is planning a full-service outpatient medical clinic adjacent to Beaumont. The new facility would replace the existing VA outpatient clinic, which is not only some distance from Beaumont Army Medical Center, but is also under-sized for the projected outpatient workload resulting from this venture.

- o East Central Florida - A new VA medical center is planned for East Central Florida in FY 1992. The proposed hospital would include more than 400 beds. Discussions are being held with the Air Force and the Navy to explore sharing options.

- o Lawton, Oklahoma - The VA has come to tentative agreement with the Army for a free-standing VA Satellite Clinic to be built contiguous to the replacement Army Medical Center being constructed at Fort Sill. The VA clinic building would be able to take advantage of a number of clinical and administrative support services available from the Army hospital and allows the Army to receive selected specialized clinical support from the VA. Target date for VA construction is FY 1991.

- o Tucson, Arizona - The VA and the Air Force are considering a new VA-Air Force bed building. The new building would replace the 60-year-old Tucson nursing units and the USAF Hospital Davis-Monthan. Located adjacent to existing VA Medical Center operations, this construction would allow DoD patients to have access to a much wider and more cost effective range of VA services. The building, planned for construction in FY 1992, would contain as many as 312 VA beds and 77 Air Force beds. The Air Force plans to build an ambulatory care clinic adjacent to the new construction.

QUESTIONS OF THE HONORABLE JOHN PAUL HAMMERSCHMIDT
TO THE HONORABLE THOMAS K. TURNAGE
VETERANS ADMINISTRATION
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE HEARING
MARCH 16, 1988

QUESTION 1: On page 8 of your testimony, you state that in unadjusted and aggregate figures your study found a need for 1.325 billion dollars for corrective action. You then stated that of this identified work 10% has been either completed or funded and that another 69% has already been planned for in various Medical Centers' 5-year plans. Recognizing that the 69% in the 5-year plans may not be funded or requested during the next five years, are you saying that if it was that that amount plus 10% already funded plus the difference between these figures and 1.325 billion would allow you to correct all presently known deficiencies in all the VA hospitals and clinics?

RESPONSE: The capital facilities studies examined the physical plants condition of 132 VA Medical Centers built prior to 1970. These studies considered such areas as electrical, fire protection, plumbing, etc. The studies did not address the adequacy nor functional appropriateness of space. Thus, were funding available to correct the deficiencies identified in these studies, all deficiencies in the VA system would not be corrected. The Facility Development Planning process which is now in its pilot phase, will address the space and functional needs. There remains the need to conduct capital facility studies at the forty remaining medical centers. The FDPs, in conjunction with the capital facilities studies, will provide the Agency with a complete assessment of the facilities of the VA health care system.

QUESTION 2: Does the staffing, particularly in nursing, exist for the proposed 289 bed conversion proposed for FY 1989?

RESPONSE: There will be sufficient staff to care for the occupants of the NHC beds acquired through conversion. For the medical care appropriation in total, the FTEE level does not change due to this action but results in a more appropriate accounting by activity (shift from hospital to nursing) of where staff are needed. The staffing ratio of FTEE to beds (or census) in this initiative is approximately the 1987 actual reported staffing ratios for the VA nursing home activity.

QUESTION 3: What does the VA see in the next 5-10 years as being needed for nursing beds?

RESPONSE: At the end of FY 1987 VA had 11,873 operating nursing home beds. For planning purposes, a need for 15,298 nursing home beds is projected for the end of year 1992.

The long range planning horizon used by the VA is the year 2000. In the most recently completed MEDIPP (Medical District Initiated Program Planning) cycle, it was determined that there is a need for a total of 19,253 VA nursing home care beds by the year 2000. (+7380 beds over EOFY 1987).

QUESTION 4: Please give us for the record a breakdown of the reduction of 140 full-time employees in the Office of Facilities since your reorganization.

RESPONSE: In FY 1984, the Office of Construction had an actual FTEE level of 762 and Facility Engineering, Planning, and Construction Service within the Department of Medicine and Surgery had an FTEE level of 105 for a combined total of 867 FTEE. Our current FTEE estimate for the Office of Facilities in FY 1989 is 727. The breakdown of this 140 reduction is as follows:

Staff offices	- 30
Planning and program development	- 60
Technical services (Architecture and Engineering)	- 14
Project management	- 9
Field supervision	- 27
Total	-140

QUESTION 5: Since your reorganization which resulted in having an Office of Facilities, has any duplication been noted in the Department of Medicine and Surgery?

RESPONSE: No duplication has been noted in the Department of Medicine and Surgery since the reorganization which created the Office of Facilities.

QUESTION 6: It is noted that you plan to develop 90,000 acres of land at Calverton, New York. How far into the future does this take you?

RESPONSE: With 90,000 graves planned for Calverton, New York, it is projected gravesites will be available until the year 2003 at this location. This projection assumes the cemetery is completed and activated in 1994.

QUESTION 7: What are the prospects that the 289 bed conversions proposed for FY 1989 will actually occur?

RESPONSE: Planning for bed conversions is conducted through the MEDIPP process. The conversions proposed in the budget represent the best information available at the time the budget is prepared and represents our best judgment of the conversions that can be accomplished. Subsequent to preparation of the budget estimates, the planning process continues and, based on this reassessment, revisions to our initial plans are inevitable based on unanticipated developments, i.e., delays because of required construction projects to meet accreditation standards, construction delays due to asbestos removal, and newly identified need for acute care beds (AIDS).

In the past, we have failed to keep the Congress informed of changes to our original plans. In order to rectify this situation, we are immediately instituting a quarterly monitoring and approval system whereby we will be able to better identify when changes occur to what has been planned for in the budget. In the future, we will notify the Congress of revisions to our plans in a timely manner.